Carving Out A Place:
Establishing A New Nurse Practitioner Practice
In Rural And Remote Canada

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Across the country, the development of legislation and new employment opportunities are encouraging the implementation of nurse practitioners (NPs) in a variety of settings. There is limited research, particularly in the Canadian health care context on how new NPs enter a community and establish a practice or what sustains them in their practice. This thesis is a qualitative interpretive study of the experiences of six nurse practitioners as they establish new NP practices in rural and remote communities across Canada. Carving out a place for practice was a challenging process that requires time and support in order for the NP to develop a presence. As the first and only NPs in their communities, resources including appropriate policies, administrative and clerical support, and mentorship opportunities are needed to support the development of these new roles and promote job satisfaction and ultimately retention of these much needed health care providers.

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Chapter One: Introduction

Approximately one fifth of Canadians live in rural and remote areas (Canadian Institute for Health Information, 2002) yet the vast majority of nursing research studies have been on acute care practice in urban Canada. There has been little focus on rural nursing practice and even less research on rural nurse practitioners. Several commissions and reports recommend further development of the role of the nurse practitioner in support of the move towards primary health care and health care reform in Canada (e.g. Advisory Committee on Health Human Resources, 2001; Canadian Nurses Association, 2006; Romanow, 2002).

Across the country, the development of legislation and new employment opportunities are encouraging the implementation of NPs in a variety of acute care and primary care settings. In the literature the roles and practices of NPs are reviewed primarily from the perspective of availability, quality, and accessibility of health care services. The NP is a new health care provider role, practicing independently in rural and remote communities. There is little information on how new NPs enter a community and establish a practice or what sustains them in their practice. There is limited research, particularly in the Canadian health care context from the perspective of NPs themselves. Without some perspective from the experience of establishing a new NP practice in rural and remote communities, knowledge of appropriate, context specific supports to recruit and retain NPs in rural communities is limited. The predicted continuing shortage of health care providers in Canada means that NPs are likely to be the sole NP in their rural and remote communities for some time. Reducing the barriers and supporting NPs as they

establish their practices are vital to enhancing job satisfaction and retaining these new health care providers.

This thesis discusses the experiences of six primary health care nurse practitioners (NPs), from the national study, "The Nature of Nursing Practice in Rural and Remote Canada." The aim of this three year study was to develop an understanding of nursing practice in rural and remote communities, in a variety of work settings, to aid in the development of strategies for education, policy and management (MacLeod, Kulig, Stewart, Pitblado, & Knock, 2004). The national study used Statistics Canada's definition of rural communities as those having a population of 10,000 or less located outside of the commuting zone of a large urban centre (du Plessis, Beshiri, Bollman, & Clemenson, 2002). The framework of the study consisted of four main approaches: an analysis of documents that describe policies and standards for nursing practice in rural and remote communities (Kulig et al., 2003); a national survey of nurses working in rural and remote communities about their practice (Stewart, D'Arcy, Pitblado, Forbes et al., 2005a); analysis of the Registered Nurses Database (RNDB) for statistical information about rural and small town nurses (CIHI, 2002); and, an analysis of narratives where nurses describe their practice. I have been the study coordinator and have used data from the narrative portion of the study for my thesis.

While the narrative component of the national study provided rich data on the diversity and complexity of rural nursing practice, it also offered the opportunity to examine in-depth aspects of particular practitioners. The national study began in 2001 before many provinces had recognized NPs and their practice. The Canadian

Institute for Health Information (CIHI) did not separately identify NPs until 2003 however some of the participants were identified as NPs in emerging NP roles. In a number of interviews with NPs the struggles with their new roles were evident. For my thesis I chose to focus on these NPs in order to better understand the issues and opportunities for these new health care providers. Since the study began, there has been further exploration of NPs in Canada through the Canadian Nurse Practitioner Initiative (CNA, 2006a).

Rural and remote nurses working in advanced practice roles may be providing similar nursing care in their respective communities but their job titles vary: outpost nurse, community health nurse, nurse practitioner, or nurse. Clarity of job description and expectations of practice have become recognized as needed to establish a new NP practice (Hasselback et al., 2003; Gould, Johnstone, & Wasylkiw, 2007). Separate legislation has been a main step in recognizing NPs as advanced practice nurses with a specific role in providing health care.

The national framework for Advanced Nursing Practice developed by the Canadian Nurses Association (CNA) has been a key document in providing a national direction on the vision of advanced nursing practice roles in Canada (CNA, 2002). It identifies advanced nursing practice (ANP) as an umbrella term that describes care of clients where the nurse uses all of his/her in-depth nursing knowledge and skills to not only to meet the health care needs, but also to advance nursing knowledge and the profession. Clinical nurse specialist (CNS) and nurse practitioner are two recognized ANP roles. Recently, CNA (CNA, 2006b) has created the following definition of a nurse practitioner.

Nurse practitioners are registered nurses with additional educational preparation and experience who possess and demonstrate the competencies to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform specific procedures within their legislated scope of practice. (p.4)

Two common designations for NPs are acute care or primary care nurse practitioner. As an integral part of the health care team, acute care nurse practitioners work on specialized medical or surgical hospital units managing the medical, educational, and psychosocial needs of patients with complex and chronic health conditions (Sidani et al., 2000). Primary health care nurse practitioners are community-based. The most comprehensive description of a primary health care NP's practice comes from the Nurse Practitioner Association of Ontario (NPAO): "a primary health care nurse practitioner provides individuals, families, groups, and communities with health services in health promotion, disease and injury prevention, cure, rehabilitation and support" (NPAO, 2007). This means that primary health care NPs have a wide scope of practice, working with people throughout the lifespan, incorporating a variety of health education, care, and support into their work with individuals, groups, and communities.

Overall, there are very few nurse practitioners in Canada compared to the United States: 1,026 Canadian NPs in 2005 (CIHI, 2006) compared to an estimated 120,000 in the United States (American Association of Nurse Practitioners, 2007). An analysis of the RNDB sheds some light on the number of NPs working in primary health care. In 2005, while more than 40% of NPs work in community health, 8.2% indicated their primary area of responsibility as community health and 52.1% provided *other direct care* (CIHI, 2006, p.16). Since primary health care NPs are

community based, further investigation of the NPs providing *other direct care* is needed to determine if they are in fact primary health care NPs.

With very limited information known about the number of primary care NPs and where they may be practicing, it is not surprising that little is known about their practice or the experience of establishing a practice. With the NP role being so new, and there being so few of them setting up practices in rural and remote communities, this thesis contributes to an understanding of what it is like to start a new practice in a new community.

Research Question

The research question that guided this study was: what is the experience of nurse practitioners in establishing a new NP practice in a rural or remote community in Canada? Through the qualitative approach of interpretive description, interviews of six nurse practitioners in primary health care roles were analyzed to learn more about what it was like as they began their NP practice; what helped or hindered the development of their practice; and how working in a rural or remote community influenced the development of their practice.

My interest in this topic arose from growing up in a rural community. I began my nursing career in the local hospital, and even though there were some specialists and a number of general practitioners in town, I learned first hand from experienced rural acute care nurses the resourcefulness and the large body of knowledge needed in providing care in a rural community. As a new graduate I appreciated the support and mentorship from colleagues while I consolidated my skills and knowledge into my daily practice. Interviewing nurses in all areas of practice for the

narrative portion of the national study reaffirmed for me the advanced skills that all rural nurses use everyday and how being the nurse in a small community, where everyone knows who you are and what you do for a living, is different than in an urban setting. The majority of the rural nurses interviewed were in established roles in their communities. But a few NPs I interviewed moved to the community to be the first NP. I was interested in learning from these participants what it was like to start from the beginning and build a rural nursing practice as an NP.

This thesis is organized into seven chapters. Chapter Two reviews the relevant literature on rural nursing and nurse practitioners to gain an understanding of the context of rural practice and the history of nurse practitioner practice. Chapter Three describes the research design, qualitative methodology, and methodological considerations. There is a profile of each of the participants, their work places, and communities in Chapter Four. Chapter Five explores the experiences of establishing a new NP practice. The findings of this study are related to the literature in Chapter Six. The final chapter summarizes experience of establishing rural and remote NP practices citing the implications of the study, the limitations of the study, and suggests opportunities for future research.

Chapter Two: Literature Review

This study will explore the experience of establishing a new nurse practitioner

practice in rural and remote Canadian communities from the perspective of the NPs.

Nurses providing health care in rural and remote Canada face unique issues related

to the geographical, economical, and social characteristics of the communities. The

review of relevant international and national research on rural nursing provides a

context for rural NP practice and the current issues in health care provision including

recruitment and retention. The role of nurse practitioners in Canada has received

recent attention through the Canadian Nurse Practitioner Initiative (CNPI). As the NP

role is relatively new in Canada and the research is limited, the international

literature was explored and revealed ongoing concerns with the NPs as health care

providers and implementation of NP roles. Minimal research on the establishment of

new NP practices is available.

Rural Nursing

The similarities in health care systems, economies, and distribution of rural

populations between Australia, the United States (US), and Canada are important

factors in reviewing literature that may be relevant to the Canadian context for rural

nursing practice. Research on rural nursing is on the rise internationally with much of

the literature coming from Australia and the US. In Canada research on rural and

remote nursing practice is just beginning. The national study, *Nursing Practice in*

Rural and Remote Canada (MacLeod, Kulig, Stewart, & Pitblado, 2004), of which

this research is a small part, is the first of its kind in this country to focus on an

understanding of rural nursing practice.

Rural Nursing in Australia and the US

Due to the international shortage of healthcare providers, particularly in rural communities, and the looming crisis in provision of care with limited human resources, much of the Australian and US literature has focused on developing an understanding of rural nursing practice from the perspective of recruitment and retention strategies (Bushy, 2002; Hegney, Pearson, & McCarthy, 1997). The characteristics of practice that encourage and support nurses to work and to stay in the community have been explored both quantitatively and qualitatively, predominantly in Australia and the US.

The Australian research on recruitment, retention, and job satisfaction of rural nurses, identifies particular characteristics of rural nursing practice and the influence of the context of the rural environment on practice. Sparse numbers of people over large geographical regions and limited on-site support services for health care providers can characterize the rural environment (Hegney, Pearson, & McCarthy, 1997). In settings with these characteristics, rural nurses may have to limit the type of services they provide (e.g. time spent providing emergency and trauma care means less or no time for health promotion and education activities); they work in an expanded practice role often with minimal educational preparation (Hegney & McCarthy, 2000). In a study on rural nursing job satisfaction Hegney and McCarthy (2000) found rural acute care nurses have high levels of job satisfaction due to their generalist practice, positive community relationships, and the holistic care they provide. Overall, rural nurses were dissatisfied with the lack of recognition from urban colleagues for the generalist practice of rural nurses. The lack of

administrative resources meant rural nurses spend more time on non-nursing duties. A second article using the same research data cited the physical and emotional demands of rural nursing practice and the lack of recognition by management as main reasons why rural nurses resigned from rural nursing positions (Hegney, McCarthy, Rogers-Clark, & Gorman, 2002b).

Hegney, McCarthy, Rogers-Clark and Gorman (2002a) identified three major attractions of rural nursing practice. Firstly, nurses were attracted to the diversity in the advanced generalist practice and the autonomy of their practice. Secondly, rural nurses were satisfied with their job and the team approach to practice. Thirdly, personal influences related to living in a rural community including the proximity of family, quality of rural life, and previous experience working and living in a rural community were identified as attractions to rural nursing (Hegney, McCarthy, Rogers-Clark, & Gorman, 2002a).

The personal connection with the community was explored in a study on mentoring rural nurses (Mills, Francis, & Bonner, 2007). This study revealed how experienced rural nurses are able to mentor novice nurses on the complexities of living and working in a small community. "Live my work" summarizes the interconnection between being a nurse and a member of the community and how the nurses' actions inside and outside of the workplace influence relationships. It is important to understand the unique aspects of mentoring new nurses about the implications of living and working in a rural community in an effort to recruit and retain nurses to rural practice.

Similar characteristics of rural nursing practice have been identified in the American literature (American Nurses Association, 1996). These include high visibility of the nurse and the close ties to the community which lead to a blurring of the personal and professional life of the individual nurse. There is independence and autonomy in the generalist practice of rural nurses that is linked to the isolation and distance of tertiary health care services (Bigbee, 1993). The main challenge of rural practice is the lack of resources, which may include facilities, services, and providers needed to support those providing health care service (Bushy, 2002).

MacPhee and Scott (2002) recently used the Social Network Questionnaire to explore the aspects of social support, both structural and functional, as well as satisfaction with support perceived by rural nurses in 10 rural hospitals in Colorado. While generalizing the results is difficult because of the very specific sampling from one rural region in Colorado, the study does highlight two main sources of support for nurses. The study found that younger nurses rely more on peer support while older nurses look to local management for support. From the perspective of support for practice, this study suggests that like the nurses in the hospital, the local management has a generalist role that included providing guidance and support. What is not known is the perceived support for practice when management is not on-site or when the numbers of colleagues are limited.

While this research may be helpful for comparison and/or background information, the differences in health care systems, legislation governing nurses, and the educational preparation for nurses in each country can make it difficult and sometimes inappropriate to generalize the findings to Canada (Haines, 1993; Sidani

et al., 2000). To effectively recruit and retain nurses, an understanding of Canadian practice is needed to implement appropriate strategies.

Rural and Remote Nursing in Canada

Research on rural nursing in Canada has been very limited. The "We're It" study (MacLeod, 1998) was an action research project exploring the taken for granted aspects of rural acute care nursing practice in small hospitals in northern British Columbia. It described the generalist practice of the nurses, the interconnection between being a nurse and a member of the community, and the accountability and responsibility of being the only 24 hour service in the community. Following on this study, *The Nature of Nursing Practice in Rural and Remote Canada* study is the first to describe the demographic characteristics of rural and remote nurses, and the complexity of their practices in a variety of settings at a national level (MacLeod, Kulig, Stewart, & Pitblado, 2004). Analysis of the RNDB has shown that as the nursing shortage continues, the total number of nurses working in rural communities is decreasing while the population overall has increased, meaning there are fewer nurses to care for more people. Even though the average age for rural RNs is less than their urban counterparts, fewer are prepared at the Bachelor degree level than in urban communities (CIHI, 2002).

The survey portion of the national study has described the generalist and advanced nursing practice of rural nurses (Stewart, D'Arcy, Pitblado, Morgan, et al, 2005). Of the 3,933 nurses who responded to the survey (response rate of 68%), 39% worked in a hospital setting, 11% in community health, and 13% in nursing stations. Yet half of the nurses were involved in health promotion activities and one

third used advanced nursing practice protocols (p.7-8). The complexity of rural and remote nursing practice was vastly underestimated in the policies and documents reviewed in the documentary analysis (Kulig et al., 2003). Rural and remote nurses are working with fewer clinical supports; leadership from management and clinical leaders is often from a distance (MacLeod, Kulig, Stewart, & Pitblado, 2004).

A sub-analysis of the survey data revealed that 33% of all the RNs responding considered their practice as advanced nursing practice, yet only 4% were in NP positions and less than half of those NPs had the specific education for their role (Stewart & MacLeod, 2005). For three quarters of the NP respondents their practice included prenatal and postnatal care, prescribing and dispensing medications, immunizations, suturing, pap smears, and being on call. The vast majority of NPs were satisfied with their broad scope of practice and their work community, yet almost one third were planning to leave their current positions within the next year. While this national study provides insight into who are rural NPs and what their practice includes, there is a lack of research on how to support and sustain rural and remote NPs in their practice in Canada.

Nurse Practitioners

Initially developed in the mid 1970s, the nurse practitioner role in Canada was the response to the shortage of physicians, particularly in rural under-serviced communities. Education programs for NPs were discontinued in the early 1980s when the physician supply increased (Dunn & Nicklin, 1995). A number of factors have prevented the integration of the NP role into the health care system including the lack of legislative and remuneration frameworks as well as a lack of

understanding and acceptance of the role by the public (Fahey-Walsh, 2004; Glenn et al, 1997). The resurgence of NPs as health care providers that began in the late 1990s was in response to a shift in health care towards improving primary health care services. Recent implementation of legislation specific to NPs and remuneration frameworks in some work settings have assisted in the integration of the NP role. The NP literature highlights the continuing supports and barriers to implementing the NP role. Although the research on NPs in Canada is increasing, few studies delineate rural or remote NP practice.

The Canadian Nurse Practitioner Initiative (CNPI) project developed a framework for the integration and sustainability of the nurse practitioner role in Canada's health system (CNA, 2006b). The framework was developed from of a review of the relevant national and international literature along with focus groups and interviews with key informants. The framework addresses many of the issues that hinder the full implementation and acceptance of NPs as practitioners in Canada, including role definition, education, legislation, regulation, core competencies, and strategies to reduce identified barriers to practice. Similar to previous national documents on advanced practice nursing (CNA, 2002), the unique context of rural or remote nursing practice is not identified in the CNPI.

Provincial and territorial NP legislation regulates the profession through education requirements, core competencies, and the scope of practice for NPs. Regulation of the profession includes title protection. While all Registered Nurses (RNs) in Canada have title protection, it is not the same for nurse practitioners. As of 2006, eight provinces and territories have legislation in place for nurse practitioners

with slight variations in the protected titles: NP (New Brunswick, Nova Scotia, Prince Edward Island, Alberta, British Columbia, Newfoundland and Labrador, Northwest Territories, and Nunavut Territory) and RN (NP) in Saskatchewan. In Quebec those working in nurse practitioner roles can use the title Specialized Nurse Practitioner (CIHI, 2006). In Manitoba where nurse practitioner is not a protected title, RN (EP), registered nurse extended practice is the title used for nurses providing care similar to NPs in other provinces (College of Registered Nurses of Manitoba, 2005). In Ontario, for those nurses registered and regulated as Extended Class RN (EC) since 1998, the title Nurse Practitioner became a protected title in 2007. There are four Ontario NP specialties: NP-Primary Health Care, NP-Paediatrics, NP-Adult, and NP-Anaesthesia (College of Registered Nurses of Ontario, 2007). In the Yukon Territory, the *Registered Nurses Professions Act (1994)* includes a broad enough definition of nursing to include those practices of nurses working in rural and remote communities often associated with NP practice, namely prescribing drugs, and diagnosing and treating health issues (Yukon Registered Nurses Association, 2004). Currently the professional association for the Yukon is in the process of developing a regulatory framework for nurse practitioners that will result in changes to legislation (YRNA, 2007). The titles reflect the different roles, scope of practice, and required education to be a nurse practitioner across Canada (Kulig et al., 2003).

These variations in NP practice are not unique to Canada. Although NPs have been practicing in the US since the 1960s and there are more than 100,000 of them (Miller, Snyder, & Lindeke, 2005), the US also struggles with clearly defining the roles of nurse practitioners (Fenton & Brykczynski, 1993; Sellards & Mills, 1995).

Similar to Canada, there is inconsistency from state to state in their regulation of advanced practice nurses as well as the education, certification, and title protection (National Council of State Boards of Nursing, 2006).

Along with variations in titles and legislation, there are provincial differences in the scope of practice and level of autonomy for NPs in Canada, particularly primary health care NPs. NP legislation includes the following functions in the scope of practice: diagnose common medical conditions, order and interpret screening and diagnostic tests, and prescribe medications (CIHI, 2006). A CNPI discussion paper (Fahey-Walsh, 2004) identified that the processes for defining the specifics of NP scope of practice vary in each province or territory. Nova Scotia and New Brunswick, for example, to update the list of medications an NP can prescribe, a multi-stakeholder committee grants approval while Ontario requires government cabinet approval following a lengthy consultation process.

The CNPI discussion paper also identifies varying levels of autonomy in practice for NPs. The autonomy of an NP's practice relates to the models of practice and expectations of collaboration with other health care professionals, namely physicians. While the literature supports collaboration with physicians, some provinces have legislation regarding this relationship. Nova Scotia and New Brunswick, for example legislate that NPs must have a formal collaborative practice agreement with a collaborating physician in order to practice. In other provinces such as British Columbia and Alberta, NPs have more flexibility in how and when they collaborate with physicians as the expectations for collaboration are referred to in provincial standards and competency documents (Fahey-Walsh, 2004).

The development of legislation for nurse practitioners is important to the integration of NPs into the Canadian health care system. Recommendations from the CNPI for future development and implementation of a national legislative framework for the regulation, education requirements, scope of practice, and autonomy of NPs will help to develop a common understanding of the expectations of nurse practitioners as care providers and support the implementation of NP roles (CNA, 2006b). Yet NPs are currently working in rural and remote communities with varied education, scope of practice, autonomy, and legislation and little is known on how to support them in the implementation of their practice.

Implementation of NP roles

Ontario was the first province to have legislation specific to nurse practitioners with changes to the Nurses Act (1991). Much of the earlier research on implementing NP roles therefore occurred in Ontario which focused on the experiences of implementing acute care and urban NP roles.

Three Ontario studies explored the implementation of acute care nurse practitioners. The first study surveyed 57 NPs in 11 hospitals in two cities in Ontario (Sidani et al., 2000). This study focused mostly on the components of the NPs' practice in relation to other health care providers in the hospital setting. The delineation of NP and medical resident roles was described as the resident focusing on the disease process and the NP focusing on the person, management of chronic conditions, and coordinating care. The holistic nature of NP practice of looking at the whole person was reflected in the findings.

The second study surveyed NPs, physicians, administrators, and staff nurses in four urban hospitals to explore successes and barriers to implementing the NP role (Van Soeren & Micevski, 2001). While the majority of the NPs reported to both nursing and medical administrators, the compensation for the NP role was either from the nursing or a specific program budget. Each group of participants ranked five indicators for successful implementation of the NP role. All participant groups viewed the level of preparation for the NP role to be the most important factor for success. Support from physicians ranked second by all groups except staff nurses, who viewed support from the program manager second. Barriers to implementation varied by group of participants. NPs ranked the lack of mentorship as the highest perceived barrier; physicians, the lack of knowledge of the role; staff nurses, the lack physician support; and administrators, the lack of support from program managers. In summary, all groups saw the continuity of care for patients as a positive aspect of the implementation of the NP role, and clarification of the NP role prior to implementation was a key recommendation.

The most recent study, while exploring the roles of acute care oncology advanced practice nurses (APN), many of whom were NPs, also identified two barriers to role implementation (Bryant-Lukosius et al., 2007). Inconsistency with the expectations of the oncology APN practice influenced the lack of understanding of the role. Almost half of the 73 participants were in their first APN role. Three quarters of the participants reported working overtime hours, which may be due to being a new practitioner or to excessive work demands.

These three Canadian studies of acute, urban NPs highlight some of the issues regarding the implementation of the NP role. Lack of knowledge of the NP role influences what practice could or should look like in context with other health care team members and client needs. Identified in the urban settings are the barriers to implementation of the NP role, including a lack of mentors, and support from leaders and allied health care professionals. Not explored sufficiently in the Canadian literature are the barriers and supports to implementation of rural or remote NP practice.

The recent literature review on primary health care delivery for the CNPI (Jones & Way, 2004) provides some insight into barriers to implementing collaborative practice with NPs and physicians. The limited Canadian literature focuses on reports from a few pilot primary care collaborative practice projects. The purpose for many of the projects was to increase services and access to under-serviced areas, some of which are rural. While the evaluation of the projects focused on the impact of services provided, facilitators and barriers to collaboration between NPs and physicians were also identified. Knowledge of the NP role and scope of practice was identified as the main factor influencing the development of a collaborative team. For example, when there was an understanding of the parameters of the NP practice this was seen as a facilitator to team building (Hasselback et al., 2003; IBM Business Consulting Services, 2003; OMA & RNAO, 2003). The lack of understanding and acceptance of the NP role by physicians and others was viewed as a barrier to the development of collaborative teams (Health and Community Services Province of Newfoundland & Labrador, 2001).

In the international literature research on the implementation of rural NP practice is limited. In the US, one recent study identified barriers to NP practice in one state. Both urban and rural NPs, 292 participants (60% response rate), perceived the lack of understanding of the NP role by the public and physicians as a main barrier to practice. When in the process of building their practice, rural NPs identified the lack of peer support and workplace support as the number one barrier to their practice (Lindeke, Bly, & Wilcox, 2001). This study was repeated three times over a 7 year span with lack of public knowledge and a peer network consistently in the top five barriers to rural NP practice (Lindeke, Grabau, & Jukkala, 2004; Lindeke, Jukkala, & Tanner, 2005).

The Australian literature has identified ways to support remote area nurses (RAN). The RAN is equivalent to Canadian outpost nurses who are nurses working in remote communities in an enhanced practice role, a role in Canada that precedes the current NP legislated practice. In a qualitative study of 57 RANs in remote communities, five areas of support were identified (Cramer, 1995). Administration was seen as supportive when there was an understanding of the RAN role and ability to assist with problem solving; there was uncertainty regarding the responsibilities of the RAN when policies were not in place to guide practice. Most of the participants felt supported in their practice by the physicians, particularly those who had an understanding of the role and the community which lead to realistic expectations of care. Barriers to their practice included cultural issues, expectations of providing care on a 24-hour basis, a lack of relevant continuing education with hands-on experience, and the ability to leave the community for education. The

availability of nurse colleagues for practical and moral support was identified as the most important support for RANs.

The study by Cramer (1995) is the first in Australia to identify the impact of the community context on practice. A recently developed model identifies four core drivers of the rural and remote context that influence the quality of care provided by advanced practice nurses (Burley & Greene, 2007). The first driver is the system which refers to legislation, workforce issues, and the political environment. Organization drivers include the model of health care delivery, policies, and procedures. The third driver is the community itself: socio-economic and environmental factors, services available, and the dynamics of the people in the community. The fourth and final driver is the individual client, including their health and cultural beliefs, previous illness experiences, and experiences with health care providers. As the health care provider, the nurse is the connector of the four drivers directly influencing the quality of care provided in the community. Burley and Greene (2007) not only identify key drivers of quality care in rural and remote communities, but also identify the influence of the context of practice on care provision.

Understanding the various factors and influences in the individual community is important for the successful integration of the NP role into a new community. Part of the CNPI was the development of an Implementation and Evaluation Toolkit (CNA, 2006a). This comprehensive document, encourages identification of many of the barriers and supports noted in the Canadian and international literature. It is for the implementation of NPs in all areas of practice – acute and primary health care in

urban and rural settings. It is not known if the toolkit has been used yet to guide the implementation of a new NP practice in either an urban or rural setting.

Establishing a NP Practice

Very few studies have explored establishing an NP practice from the perspective of the NP in primary health care and/or rural health settings. Those studies that have examined the process have described the stages of transitioning into a new role for newly graduated NPs as well as challenges facing primary health care NPs in establishing a practice.

Two US studies explored the development of new NPs in their first year of practice. In their 1997 grounded theory study of 35 primary care nurse practitioners in Washington, Brown and Olshansky developed a theoretical model that depicts how newly graduated NPs develop confidence as they consolidate their advanced practice skills, moving from feeling like an imposter to a legitimate care provider. The focus of this study was on the transition from student to practitioner; not explored was the influence of the context of practice. The authors identify new NPs as vulnerable in their first years of practice and recommend further study on how to support new nurse practitioners.

In the second study, new NPs identified uncertainty in the development of their practice and feelings of isolation as barriers in transitioning into their new roles (Kelly & Mathews, 2001). This qualitative study of 21 recent NP graduates from a large US university, explored through constant comparative analysis of the interviews the experiences as these graduates entered their first NP position. Although the size of the communities was not available from the data, the

researchers noted that most nurse practitioners were practicing in small towns and many were the first NP in the community. This study showed that NPs in small communities found lack of role definition, privacy, confidentiality, and isolation as challenges to the development of their practice. Physician support, identified as key to the development of their practices, helped the NPs' confidence, and in some situations helped the NP gain credibility with clients and the community.

In a recent Canadian study, seven rural primary health care NPs were interviewed to investigate their experiences in their first year of practice (Gould, Johnstone, & Wasylkiw, 2007). Content analysis revealed three main themes: philosophy of care for NPs, barriers to practice, and being a pioneer. The additional time spent with clients and working in partnership with clients was found to be central to the NP's philosophy of care. Barriers to practice included limited acceptance of the NP role by clients and other health care professionals. System barriers related to the fee for service model of remuneration for physicians. The presence of the NP posed a threat to the family physician's income as NPs provided care previously billed by the physician and specialists received a lower fee for a referral from a NP than a family physician. The final theme identified the positive outlook of the NPs as they developed their role within their province, seeing themselves as pioneers in establishing a dimension of health care provided by nurses.

All of these studies identified support for the NP in their first years of practice, through mentorship opportunities and collegial support from other NPs. What needs further understanding is the effect of working in a Canadian rural or remote

community on the provision of these supports for practice. Some of the identified barriers to the establishment of a new practice were role ambiguity including a lack of understanding of the scope of practice for NPs by physician colleagues. What is not known is if there are other barriers to establishing a new NP practice, particularly those related to the context of a rural or remote practice.

Summary

The recent attention in the literature to nurse practitioners as viable and needed health care providers has provided a place to start in the development of NP roles in Canada. The Canadian Nurse Practitioner Initiative recommendations and framework provide a national cohesive platform for the development and implementation of NPs in Canada. However, the CNPI does not take in to account the unique characteristics of rural nursing practice and the impact these may have on the development of a rural nurse practitioner practice. The context of practice is particularly important when looking at supporting NPs and limiting the barriers identified in the literature. The international literature that focuses on rural nurse practitioner roles is helpful as it raises the awareness of the differences in rural practice from urban NP practice. But the different health care systems, education, legislation, and scope of practice limit the applicability to the Canadian context. What has not been sufficiently explored in the Canadian literature is the experience of establishing rural NP practice or how to support these new practitioners as sustainable health care providers for rural Canada.

Chapter Three: Methodology

Research Approach

The research approach that informs this study is qualitative interpretive description. Many methodologies used in nursing research are founded in other disciplines including sociology and anthropology (Priest, Roberts, & Woods, 2002). Interpretive description, while drawing upon these methodologies, has been proposed by nursing researchers (Thorne, Reimer Kirkham, & MacDonald-Emes, 1997) as a research approach grounded in the epistemological foundation of nursing as a separate and unique discipline. Through inductive analysis of the narrative data from individual participants, common themes that further the understanding of a known phenomenon are discovered to produce knowledge that is practical and useful (Thorne et al., 1997). Interpretive description was developed to enhance the understanding of health and illness issues, through the holistic lens of nursing that does not decontextualize to the extent of losing sight of the humanness of the research (Thorne et al., 1997). This approach is aligned with naturalistic inquiry in the understanding that the researcher interacts with the data and that because there are multiple realities within the data, theories must be derived from the data rather than constructed prior to analysis (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004). In using an interpretive descriptive approach, this research acknowledges the contribution of nursing knowledge held by the participants and the researcher in furthering the understanding of establishing a new practice for nurse practitioners. As the NPs talked about their everyday practice, the interpretive description approach enabled me to examine the participants' understanding of establishing a

new NP practice through the inductive analysis of the experiences shared in the interviews.

Data Collection

The data for this thesis is a subset of the data collected for the narrative portion of the national study, *The Nature of Nursing Practice in Rural and Remote Canada* (MacLeod, Kulig, Stewart, & Pitblado, 2004). As one of the four complementary methods, the narrative portion of the national study invited nurses to share their experiences in a telephone interview to explore the meaning of nursing practice in rural and remote communities. Interviews with 154 nurses occurred from September 2001 to January 2003. A co-investigator in Quebec conducted interviews with eleven Francophone nurses (Lazure, 2002). As the primary interviewer, I completed 113 of the 143 English telephone interviews. For this thesis, I selected six of the interviews and analyzed them through the interpretive descriptive approach.

Involvement in the study was voluntary. Recruitment strategies included word of mouth, the study's web site, as well as notices in provincial and territorial nursing magazines and newsletters. Attention was given to encouraging participation from nurses in all provinces and territories in the practice areas of community health, acute care, long-term care, and primary care. Towards the end of the data collection phase, members of the Advisory Committee for the national study contacted potential participants. For example, one of the provincial Advisory Committee members sent an email to a provincial public health nurse (PHN) email distribution list explaining the study and encouraging PHNs to contact the research coordinator if they were interested in participating.

Prior to the interview, participants consented in writing to participating in the study and allowing the interview to be recorded for transcription (Appendix B). A mutually acceptable time of about an hour was set for the telephone interview.

The interview was semi-structured in order to allow for the experience of the nurse to flow unimpeded by focused remarks (Giorgi, 1997). While grounded in naturalistic inquiry, the interpretive description methodology "draws upon the values of phenomenological data collection strategies " (Thorne et al., 2004, p. 6). The analysis approach taken for this study is congruent with the research approach of hermeneutic phenomenology for the national narrative study. The guideline for the interviews developed by the principal investigator contained open-ended questions to encourage story telling of situations by the participant (Appendix C). For example, "Can you tell me about a situation where you feel your nursing care really made a difference to a patient or family?" As well, the interview guideline contained specific questions asking the nurse "what advice would you give to a new nurse/educator/administrator?" The participant's responses guided the flow of the interview so at times not all the questions were asked. The focus of my research was determined after completion of the data collection, therefore specific questions, probing or follow up regarding the nurses' experiences in the first years of practice were not possible.

The interviews were transcribed verbatim. This included any pauses in conversation, as denoted by a period for each second of silence, and changes in speech patterns that may have indicated emotions during the interview. For example, "it was a difficult time (voice wavering)". This assisted in developing an

understanding not only of the experience as it was told, but also the underlying meaning, what was not being directly said by the participant (Van Manen, 1997) and enhanced the reliability of the interpretations (Silverman, 2005). Following each interview, I wrote field notes that included reflections on the interview overall, my developing skills as an interviewer, and my first impressions of the nurse and their practice.

Ethical Considerations

The Nursing Practice in Rural and Remote Canada Study received ethics approval from University of Northern British Columbia (UNBC), University of Lethbridge, University of Saskatchewan, and Laurentian University. This study is a primary analysis of a subset of data collected for the narrative portion of the national study housed at UNBC. The research question directly relates to the main study's objective of examining nursing practice in primary care settings; the study's ethical approval from UNBC is attached (Appendix A).

As there are so few nurse practitioners in Canada ensuring the confidentiality of the participants was paramount. People's names were abbreviated to first initial only in the transcript. Names of communities were only included in the transcription to assist with the understanding of the effect of location during the analysis of the data. Omission of community names, identifiers related to economy or location within a province or territory protected the identification of specific rural communities. Pseudonyms were used to further conceal the identity of the individuals in this study, and, where needed, gender of the person was changed.

Participants

At the time of the data collection, there was inconsistency across Canada in the use of nurse practitioner as a job title and as a protected professional title. While they did not call themselves nurse practitioners, twenty-eight participants described their practice as primary health care providers in nursing or outpost stations. An additional 18 participants identified themselves as nurse practitioners by their job title and the type of practice that they described. I selected six participants from these 18 identified NPs for my thesis.

In the current Canadian health care climate of limited health care providers, there is growing interest in expanding the nurse practitioner role into rural and remote communities. The six NPs selected for this research study are working in newly created roles as primary health care nurse practitioners, where they are the first and only NP in the community. Some of the participants are also new to the NP role. The interviews for these six participants lasted from approximately 1 ¼ to 2 hours with the average time of 80 minutes. The participants reside in four provinces from western, central, and eastern Canada. A profile of each rural community is included in Chapter Four. At the time of the interviews two participants were experienced NPs, and three of the participants were recently graduated NPs. These five participants had been working in their communities for less than three years. The final participant had been practicing in her community for five years, but when she started her practice she was a new nurse practitioner and the first NP for the community.

At one point, I considered not including this last participant because she was at a different place than the other participants who were in the process of establishing their practice. But I felt it was important to include her for two main reasons. Firstly, in the interview she talked about her early days in practice with detail and clarity as those experiences continued to shape her practice. Secondly, because she had an established practice, exploring the issues and challenges in her practice over time allowed me to compare her practice and experiences to the other five participants.

Data Analysis

Interpretive descriptive qualitative analysis is an inductive process where the researcher "comes to know the individual cases intimately, abstracting relevant common themes to produce knowledge" (Thorne et al., 1997, p. 170). Each stage of the analysis has resulted in multiple rewrites based on reflection and questioning the data. After reading each transcript many times over, and reflecting on each interview as a whole, the focus of my first round of analysis was to develop a picture of the nurses and their practice. Rather than just reading the text and looking at the pieces, by drawing out key stories and pulling together the career and life experiences of each nurse, I began to get a sense of each participant.

I became curious about doing a comparison between the nurses to see how the components of practice and the nature of the nurse might shed light on the experiences. How were the experiences of these novice practitioners different, did it relate to the context of their practice or other factors such as the length of time in their current role? This thoughtful review of data that is contradictory or challenges

the interpretations of the other interviews is an important process to advancing the credibility of the findings (MacPherson & Thorne, 2006). I started a worksheet with such categories as:

- o the newness of the role for the NP and/or community;
- o what was the practice like, e.g. layout of the clinic, on call expectations, Emergency care provided, physician on site, how much time for clinic or administration work;
- o the community's understanding of the role;
- o why was the NP role created in the community;
- o the character of relationships with physicians; location of administration.

Searching for commonalities among the participants by reordering the themes helped me to discover a pattern within the context of the experiences (Enosh & Buchbinder, 2005; Tesch, 1991). While I did not complete the worksheet for each nurse, it helped me to develop a strategy for the next steps of analysis. I found myself rereading the transcripts in a particular order. I first reviewed the three experienced nurse practitioners. They exude a confidence about their practice in several areas: what they are able to do as NPs; what their role is or could be for the community; ways of working with other health care providers. I then reviewed the other three participants who are new to the NP role but were considered to be experts in their previous nursing practice.

The second round of analysis was to describe the flavour of each interview; what was unique about each participant and their practice; how their experience as nurses, NPs, and members of the community contributed to their practice. During

this stage of analysis I began to think that my original research question was limiting the process. Originally I was interested in exploring the experience of mentorship among new nurse practitioners in order to understand how new nurse practitioners could be supported as they develop in their new roles. This focus led to my original research question of 'what is the experience of support for new nurse practitioners?'

I then moved into the third round of analysis where I began to formulate preliminary chapters based on the themes of different types of support. During this stage of analysis, I became stuck and frustrated. What I was identifying as important to each participant and their experience, was not fitting within the limiting parameters of types of support. Part of the qualitative process is to

> Move in and out of the detail in an iterative manner, asking repeatedly, 'what is happening here?' In so doing, the contextual nature of the data is respected and remains intact, and the researcher is guided to focus on, and engage in, the intellectual processes that are the corner stone of qualitative analysis (Thorne et al., 2004, p. 14)

In writing about the support for these new NPs, I realized that I was de-contextualizing the experiences in their first years of practice. By taking a step back and looking at the analysis as a whole and asking "what is happening?" I was able to redirect my research question to the experience of establishing a new NP practice, of which support is a piece but not the whole.

As I worked through the multiple phases of analysis challenging my preliminary interpretations and findings, I went beyond the original theoretical framework of examining the experience of support to one of inquiry about the experiences of establishing a new practice. In doing so, I was engaged in what Thorne et al. (2004) call a "rigorous analytical process...moving beyond the

theoretical framework from which the investigation was launched in order to advance

the initial descriptive claims toward abstracted interpretations that will illuminate the

phenomenon under investigation in a new and meaningful manner" (p.9).

Methodological Considerations

The issue of rigor in qualitative study has been debated and discussed by

many authors (Lincoln & Guba, 1985; Sandelowski, 1986), yet a unanimous

understanding has not been reached. Watson and Girard (2004) propose that for a

qualitative study to be considered scientifically sound, instead of using rigor from the

quantitative paradigm of research, that the term integrity be considered. Integrity

incorporates the concepts of honesty and wholeness. I created an honest

interpretation of the experiences of the nurse practitioners by acknowledging my

past nursing experiences and how they may influence my interpretation of the data.

For example, I acknowledged my rural experiences of working relationships with

different physicians and how my emotional reaction to my experiences may

influence my interpretation of the experiences of each of the participants in their own

situations. Acceptance of my interaction as a researcher with the data, yet ensuring

that the themes arose from the data, is consistent with the interpretive descriptive

approach. An audit trail was maintained as previous writings and rewritings of

analysis were saved and I kept a journal documenting my thought processes,

challenges, and questions throughout the analysis process. Wholeness as a concept

is also consistent with the analysis approach for this study. Exploring the

experiences of the participants occurred by looking at the pieces as well as the

entirety of the information shared in the interviews, a process similar to nursing

practice where nurses view the specific health condition in relation to the whole person. Despite the small sample size, resonance between participants on the themes was achieved. That is, while the themes were present in all of the interpretations, for some of the participants particular themes were in the foreground of their narratives and for others the themes were in the background.

Another issue that is debated in qualitative research is the validity or truthfulness of the knowledge derived from the research findings, and whether this is feasible in qualitative research given that the concept of validity originates in the quantitative paradigm (Angen, 2000). There is a shift from validity to validation of the research process by being transparent in the research process (Flick, 2006; Mason, 1996). Validation of the analysis by the participants, which is sometimes used in qualitative research, was not appropriate for this study due to the length of time from data collection to analysis and because of the interpretive nature of the analysis. Instead, the aim was for resonance with the reader. In sharing the challenges and struggles on the journey of interpretation, I have revealed who I am as a researcher and as a nurse. This is an integral part of the analytical process and by describing my thinking throughout the stages of analysis, one is able to see how the description of establishing a new NP practice arises from the interviews.

Summary

Through interpretive descriptive analysis, the experience of six nurse practitioners as they establish their practice as the first NP in their respective rural communities across Canada is explored. In this qualitative research approach and others, the integrity of the researcher and the transparency of the process of

analysis must be evident in the findings and their interpretation. While the unique contexts of the communities and the individual nurses themselves may limit the generalizability of the findings, there are valuable lessons learned from these participants to support nurse practitioners in establishing a practice in rural and remote communities.

Chapter Four: The Nurse Practitioners

An analysis of the interviews revealed that the individual participant, the community, and the workplace influence the development of a new practice for a nurse practitioner. The experiences of each nurse shape how they are as community members and as health care professionals: how they interact with people; how they will build their practice; what strengths they bring to their practice; how they meet the challenges they will face as they start in a new role. Each of the participants moved to the community for the nurse practitioner position so each has had to learn about the characteristics of the community and its people. The demographics, social and health issues, and employment status of the community give a picture of the community. The characteristics of the workplace, such as location and available allied health professionals in the clinic, are also important to understand in the development of the services the NP will provide to the people of the community.

A profile for each participant describing the community, the work environment, and the nursing careers of the NPs provides a context for the development of each of their practices. The personalities of the participants also shape the practice that they are creating. The challenges and opportunities in building a practice are as individual as the participants and their communities. All of the participants have worked in their current settings for less than 5 years, and yet they are all at different stages in the development of their practice and their connections with the community. There is a sense of progression from total newness to one of comfort and confidence.

Barbara

Barbara's interview encompasses a sense of newness in many ways. Barbara moved to this community one month after graduating from the two year Masters Degree Nurse Practitioner program in her province. The community has never had a nurse practitioner before and her role is a part of a pilot project for a Primary Care Centre that is housed in the basement of the local small hospital. Barbara is a new nurse practitioner and she is new to the community.

Barbara has spent much of her 17-year nursing career as a public health nurse. Her knowledge and previous work experience in women's health assists her with her current practice where women's health comprises 95% of her NP clinical practice.

> Some of it is just an extension of what I did before, which is nice. Because before I dealt with a lot of teenagers in public health and birth control issues, and I always thought, wouldn't it be nice if I can just give them a prescription? Wouldn't it be nice if I can just do this examination instead of sending them to the doctor? And now I can, so it's great!

This community of 3,000 with an additional 5,000 people in the surrounding rural areas is only 40 minutes from an urban centre. Some community members commute to the city for work yet there is a high level of unemployment in this community as well.

Involvement in community projects outside of the health clinic has raised Barbara's profile in the community. When she talks about 'being known' as the nurse practitioner, there is a sense of being needed and appreciated by the community.

> People are friendlier, people get to know everybody. So I'm getting to know the community as well and then they're getting to know me. Like it's amazing in the six months that I can't walk down the street without seeing quite a few already who I have seen here at the clinic, or I know from work or whatever.

People have told me 'it's great having you here and I'm so glad we can just come and see you'.

In a short period, many people of this rural community know who Barbara is and they are beginning to accept the nurse practitioner as a part of the community's new health care team.

At the time of the interview with Barbara, the Primary Health Care Centre had been open for 8 months. This new way to access health services was set up for collaborative practice with two physicians, a nurse practitioner, a mental health worker, dietician, physiotherapist, an audiologist, as well as diabetes and wellness educators. Barbara noted that in a smaller community there isn't the segregation of people based on their jobs, "everyone sits in the lunch room together, whether you're a doctor or a laundry person," and that people in the health centre genuinely want to work together. As a new nurse practitioner, one of Barbara's challenges is explaining to other health care providers and the people of the community what it is that a nurse practitioner does while she herself is learning what her role will be within the centre and the community. She summarizes her practice beautifully:

> I guess the easiest way that I found explaining to the general public what I do is that I deal mostly with well people and try to keep them well, whereas a physician will mostly deal with sicker people and try to cure them. I'm mostly in the health promotion and preventing disease in the future type of area.

This simple explanation of her practice helps people to understand where the nurse practitioner fits within existing services as well as within the new Primary Health Care Centre.

The centre operates Monday to Friday for clinic appointments with the various team members. While Barbara states that her practice is supposed to be 60%

clinical and 40% health promotion, she is spending about 25% of her practice doing management work as the centre does not have an on-site administrator. Her clinic appointments are longer than the physicians' time allotments and she incorporates health promotion and time to get to know the client into each appointment. For example, she allows at least an hour for a physical examination, spending the first 20 minutes of the appointment getting to know the client and addressing any health concerns they may have prior to the physical exam. She ends the appointment with health education and referrals to allied health care providers, such as the dietician.

Barbara is a new nurse practitioner, in a new role, in a new community so her learning curve has been steep. Barbara has focused on developing her skills and developing her practice. Her practice in women's health is an excellent fit with her areas of expertise from her previous nursing experience and it fills a gap in the health care services in the community.

Sandy

Sandy shares with Barbara the experience of being new to practice in a small community as she also was a newly graduated NP starting in a position that was not previously developed. For the past 2 ½ years, Sandy has been the nurse practitioner for a pilot project health care clinic in a small community. The focus of Sandy's interview was providing a service to the community: "I'm a primary health care nurse practitioner, so what I'm providing for the people in the area is primary care services. That's my bottom line, access to services in the best interest of the patient." Even though Sandy is a relatively new nurse practitioner and still developing her skills and

knowledge, her priority is being able to provide a wide variety of services to all people as the main health care provider for the community.

Sandy comes to the NP role with 22 years of experience in nursing, 15 of those years in the acute care tertiary hospital in a nearby community. Sandy and her husband live in another rural community that is only 10 minutes from the clinic. Unlike other NPs who are working alone, she does not provide emergency services, likely because the tertiary care hospital is only 30 minutes away. Although she is new to the people of this community, she is known by other health care providers, mainly physicians in the area who worked with her in her previous role.

> I built up quite a practice as a nurse clinician, where I would get a lot of consultations with family physicians. I think because they knew me they trusted me. They can see me in that role, because they figure if I did a good job as a nurse clinician I probably would be an okay nurse practitioner.

The respect for her nursing knowledge and skills in her previous nursing practice is the basis for the acceptance of Sandy as a nurse practitioner by physicians. The physician referrals influence the development of her practice and the types of clients she sees.

The clinic is a pilot project and it has undergone a number of changes. When Sandy started there was a physician on site 3 days a week. Now only Sandy is there on a full time basis; two physicians from other communities see clients in the clinic for a half-day per week. In the beginning, the physician at the clinic provided Sandy with direct clinical support and supervision as she developed her nurse practitioner clinical and decision-making skills. The presence of the on-site physician also allowed Sandy time to do some education in the community about who she is and what she could do for the community as a nurse practitioner. She began health

promotion and disease prevention work. This early connection with the community

outside of the walls of the clinic demonstrated to the community Sandy's willingness

to provide health care services at the convenience of the client.

> I wouldn't say home visits are a big component of my practice, but I offer that
> service, just as a different delivery mode. And I do a lot of telephone
> consultation or telephone advice. Our clinic is not really walk in, but so far I've
> been able to provide either same day service or within 24 hours, especially
> say for little wee ones who can get very ill.

Having multiple ways to access her services could potentially mean an

increase in workload for Sandy. This community is a popular summer destination for

part time residents with cottages and with tourists. The 4200 permanent residents

are a mix of younger families that commute to nearby communities for work as well

as a significant and growing number of retired people. The diversity of her practice is

challenging.

> I see all age groups, so I might see a newborn that's a couple of weeks old,
> and then we have people that are in their 90s who come to the clinic. And to
> know something about everything in between, it's hard.

The "something in between" covers the vast transient, tourist population of

close to 60,000 that come through her community in the summer months. This

dramatic increase in population affects the volume of health services. During the

winter months she sees 10-20 clients a day but in the summer her workload

increases to 30-35 clients a day.

Sandy's goal of providing a service to the community illustrates the diversity

of her practice. From non-urgent acute care services such as diagnosing and

treating otitis externa, to public health immunizations and baby checkups, to a home

assessment of a 93 year old woman with symptoms of a urinary tract infection,

Sandy does it all. And she does it with a new found appreciation for providing health care outside of an acute care setting.

> I find that working in the community is quite a bit different than working in an acute care setting, and I really like the idea that you find out about the client living in his own environment. So all the trials and tribulations that they have on a daily basis, and that you get to know them and you're able to help them through those trials and tribulations. I think that the whole idea of caring about your community really comes out.

The connection between primary health services and working with the client as a whole person in their own setting fits well with Sandy's goal of providing services for the people of the community. Sandy's practice is that of a generalist, like the old time rural family doctor.

From the stories she shares about her work experiences, she is getting to know the people of the community and her confidence is increasing in providing such a wide variety of health services to the community. Where Sandy's challenges lie are mostly in being able to provide the service that she feels the community needs and deserves when she is the only health care professional there on a full time basis.

Marion

Marion's enthusiasm for seeking new opportunities in her personal and professional life is evident throughout the interview. Marion moved with her family to this community 18 months previously. As she said, "I took this job really as an opportunity, because I felt that rural practice would offer more in terms of really good experience." Living in this rural community has provided the chance for a different lifestyle for Marion and her children. She states they have a better quality of life with

school and her workplace being closer to home; they are able to do more activities together as a family.

Marion seems to have a philosophy that learning is a continuous part of life. In her career path, it is evident that Marion takes life-long learning to heart. She has been a nurse for 18 years working in acute care and public health prior to becoming an NP.

> As a practitioner, whenever I didn't know something I immediately changed jobs so I could find out. So when I didn't know what my postpartum mothers were going home to, I went out into public health and found out. And when I didn't know how to teach women about breastfeeding, I became a lactation consultant.

This pattern of life long learning continued for Marion after completing the certificate education required in her province to practice as a nurse practitioner. She obtained a Masters degree as a Nurse Practitioner in order to have a more comprehensive knowledge base for her new nursing career. The more she knows, the more she is able to use in her practice and share with her clients.

Like the previous two participants, Marion's position is a part of a pilot project to enhance the health care services for the community. This rural community of 500 provides health care services to a rural catchment area of 3,000. Similar to Sandy's community, tourism is a large part of the economy and in the summer the population increases significantly. Although Marion does not talk about the increase in workload over the summer months, she does mention an increase in her work in general caused by the three-month wait to see one of the five physicians in the community.

Marion is a primary health care nurse practitioner in the physicians' office that is located in the local small hospital. Her vision is to have cross management of care

"so that the client's time is best spent with the right care provider." Marion's practice can be described as a generalist practice where roughly 60% of her practice is management of stable chronic conditions and approximately 20% is episodic acute illness treatment. She works with all age groups from children to the elderly. Marion can see up to 16 clients a day, setting aside 1½ hours for physicals for men and women or first prenatal visits. Like other NPs in this study, she will see clients outside of the clinic and outside of usual work hours as she believes that "primary care should happen where ever the client is, not just in the clinic." For example, in the previous year in a 2-week period, 591 people received flu shots from Marion at various locations in the community.

Spending time with clients and working in partnership with them is an important part of the care she provides. Marion encourages self-education for her clients by supporting them as they seek health information from a variety of sources.

> This client has access to the internet and so this is an outing for her, she actually gets to go to the library and use the internet and brings in information that we go through together. She also seeks care from a naturopathic doctor, so it's trying to balance out the different information that she comes in with and being open to that, rather than just shutting her down. It's trying to help her make sense of some of the information with limitations in education and her understanding.

Marion's willingness to take the time to listen and accept that those with chronic conditions often seek alternative health practices are ways that she fosters learning and self-care for her clients. Marion works in partnership with clients as they become informed and begin to take control of their health. Her clients benefit from her life long learning approach. In her interview Marion shares an experience

regarding a client diagnosed by different physicians with various chronic pain

conditions:

> I said to her, that I wanted to just open up an area that maybe hadn't been explored. She didn't necessarily have to explore that with me, but I wanted to let her know that from my experience in nursing and in life, that sometimes women that come with this kind of history have often been abused. And she looked at me, and her jaw dropped and her body changed. She said, 'you know, you're the first person that even asked or explored that and you're right, this did happen to me.'

Marion's extensive nursing experience and life learning allows her to "look at

the mind/body/spirit connectedness" of a person. The time she spends developing a

relationship with a client means that she has the chance to explore with clients how

their health is affected by their life experiences.

Seeking opportunities and learning through life shapes Marion's practice and

her interactions with clients. Her varied nursing career and willingness to continue to

learn benefits her clients in the care she provides and the partnerships for optimum

health that she creates with individuals. The opportunity to develop a practice where

the client spends the time with the right care provider in a location that is most

appropriate for the client is the goal of Marion's practice.

Theresa

Theresa is also involved in a pilot project for a newly formed health centre.

While her role in the community is new, her many years of experience as a nurse

practitioner means that she has a clear understanding of the nurse practitioner role.

This allows her to concentrate on building new teams, which is an integral part of her

practice and a theme throughout her interview.

Theresa has 10 years experience as a nurse practitioner in rural and remote nursing stations where she has developed her clinical skills including emergency care and community development skills. She is using her many skills to meet the needs of the community and the pilot project.

> Bringing my experience as an outpost nurse has been incredibly valuable because as an outpost nurse you're wearing multiple hats and that experience has helped me gel together as a family nurse practitioner so that health promotion and prevention and home care and diabetes education and chronic disease management and acute care all become melded a little bit more. So that we are able to see how we can look at optimal health for a person, in a more holistic manner.

Theresa is using her experience in outpost nursing to benefit the clients. To achieve the pilot project's goal of enhancing integration of health care with an emphasis on health promotion, most of the community based health care providers are in the building with the eight physicians in the community.

> The public health nurse is here on site. Diabetes and lipids education have been off site locally and we're going to be moving them on site in terms of trying to look at a chronic disease model that's more integrated. Right now we're still doing our own thing separately but I think the first step is getting us under the same roof and then see where we can work together.

Having the community health care providers' offices in the same building has the potential to promote better communication and faster development of working relationships. Team members will be able to learn how each of their areas of knowledge and expertise can fit within a team model to provide integrated and comprehensive care for a number of chronic health conditions.

Two aspects of her work situation have been helpful for Theresa to integrate her clinical practice into the established medical practice. One, the physicians are on an alternate payment plan so that she was not seen as being in competition for

clients. And two, she had a number of months for development of her practice before she began to see clients. Theresa was able to spend time with the physicians discussing how she could help them with education for their clients as well as meeting with the other health care providers in the community to talk about the potential for the nurse practitioner role. Through this process of team building Theresa not only learned about the educational needs of clients but was able to educate the physicians and community members on the potential role of the nurse practitioner.

Theresa has been in this practice setting for just over a year and is quickly learning about the community's unique characteristics. The community of 7,500 has mostly agriculture and resource based employment opportunities. Unlike other participants, Theresa's community has a number of different religious groups that influence the delivery of health care services, particularly to the women of the community. The community has a stable population of diverse ethnicity that has lived there for two to three generations. As new comers to this long standing community, Theresa and her husband, who do not have a religious affiliation or family connections, find themselves as outsiders in many ways. For example her husband, also a professional, is finding it difficult to even get casual work because his family is not from the area and he has not developed connections with the community through church. Having worked in much smaller and more remote communities, Theresa has learned "to just be me. If you like me, you like me. If you don't there's nothing I can do about it. But if I'm genuine and I care then it'll all work

out in the wash." The challenge for her now is building teams with different people and realizing her time limitations.

> I'm used to chairing an interagency committee that has police, school counselor, principal, drug and alcohol counselors, and clergy sitting together in a group and brainstorming. To take that kind of work and bring it into a bigger area, it's really difficult because I can see all these things that can happen but I can't do it all so partnering with all these other groups I'm hoping will help. It's been a learning curve for me to learn that I can't do it all and maybe I can just link people together and trust that it will go.

Theresa's experience with multidisciplinary teams has been a benefit for this community. Working with professionals outside healthcare helps to bring health promotion and prevention into the everyday lives of people. The challenge for Theresa is realizing that she can't do it all as she has been able to do in smaller communities with fewer team members.

Team building and health promotion and prevention activities at the community level are a main part of Theresa's role, but she also works with individual clients in the health centre. During clinic days, Monday to Thursday, she usually sees four to five patients a day. Fridays are for administration work and meetings. Based on her assessment during the development of her practice, women's health was a needed service in this community that has all male physicians, so it has become a large part of her clinical practice. Theresa's appointment times for women's physicals are usually an hour to allow her time to get to know the client. "That one hour is of real value. What happens in that hour is you're able to build a relationship. And when you build a relationship, then trust happens and when trust happens then you make a difference."

As an experienced NP, Theresa brings her knowledge to the health care she can provide. Her confidence with who she is as an NP enables her to build a team for more integrated health care.

Andrea

Andrea has the most challenging work situation of all the participants in terms of working with limited resources in the community and in her work place. The lack of resources that impacts the ongoing development of her practice is a theme throughout the interview. The community is considered a township, an unorganized community that is not a municipality which receives little funding and has limited resources. There are approximately 500-800 people living in and around the area as well as approximately 450 living on the reserve near by. Andrea only provides emergency care to the Aboriginal people as they have their own community health nurse. Logging, railway, and outdoor tourism camps provide most of the employment in the area. Its residents include many seasonal workers or those who do not work at all. With the high unemployment rate, Andrea states she deals with a lot of health concerns associated with social issues such as smoking, alcohol, and drug use.

This rural community has had sporadic health care coverage over the years. At one time, there were physicians in the community and when they left, nurses from a small hospital in another rural community provided services under physician directives. The community had some experience in working with nurses in an advanced practice role, but not nurses with a nurse practitioner scope of practice. At the time of the interview Andrea had been working in the community for 3 years, providing the community with consistent health care services. She talked about

starting to see efforts by some of the community members to make some changes to their lifestyle in terms of quitting smoking and or drinking, but noted that change is very slow.

In Andrea's community health care services are limited. In addition to herself, there is an ambulance service, and the community health nurse on the reserve. As the nurse practitioner, she provides the highest level of care. Andrea rotates with another nurse practitioner to provide care during the week, and on weekends the ambulance is the only health care service for the community. Andrea lives and works in the community one week at a time, Monday to Friday providing 24-hour service. She then has 9 days off during which she resides in an urban city that is 3 hours away by road. Support services such as x-ray, diagnostic imaging, and laboratory services are located in the same urban city that is the referral centre.

Andrea relies heavily on her extensive NP experience. She came to this community with 16 years of nursing experience, 10 of those years as a nurse practitioner in various nursing stations and outpost communities in northern Canada. Andrea's skills and knowledge give her the background for her current generalist practice. She sees mostly middle aged and older adults although she also provides prenatal care. In the interview she mentions seeing clients for management of chronic conditions such as diabetes and hypertension, pre-operative assessments, short duration illnesses including respiratory and other infections, and health promotion and prevention appointments such as Pap smears and birth control. She sees an average of 50-60 people during her 5 days of work. This includes seeing people during clinic time as well as on-call after hours. In comparison to the other

participants, Andrea's work load seems to be less, but more challenging is the

emergency care that she provides as the only health care provider working with

limited resources:

> The little clinic that I'm in, we're not really supposed to be dealing with these emergencies. But because the time factor to get to town is so long, we don't really have a choice. And I've always worked in other communities in the north where I've had at least one other nurse with me or in a bigger center I had maybe six nurses. So you always had backup help. And it makes such a difference if you have someone there with you to just help you and discuss things with you and it helps with the stress level too. To actually be there by yourself, I find that very challenging sometimes. I am the one that everyone's looking to, to provide the care and to have the knowledge and to know what to do, and to remain calm, too.

Even with her experience providing emergency care in other settings, as the

highest level of health care provider, what challenges Andrea is not having the

collegial support on site to share the responsibility for clinical decision-making.

Providing consistent care for clients is also a challenge for Andrea as this community

does not have specific physicians affiliated with the community to provide services to

the people and support for the nurse practitioner. This creates challenges for Andrea

when she needs to refer clients for emergency care and ongoing management of

acute and chronic health conditions which lie beyond her scope of practice.

> One of the downfalls is there is no designated physician for the town, so if people are fortunate enough to have their own doctor in the city they kind of go that route. And some of the doctors aren't really comfortable working one on one with a nurse practitioner. So I'll tell people that this needs to be dealt with by a physician and the doctor will do the care and not really discuss it with me at all, so their care is a bit choppy. The way it was set up with the federal government in other communities is that you had a doctor assigned to that community and that doctor knew the patients and you worked very closely with the doctor over the phone. Here, the physicians haven't really taken the community on so that sort of support isn't there 100%.

Even though the community has received consistent health care by the nurse practitioners for the past 3 years there is still fragmentation of care because of the lack of a good working relationship between physicians in the city and the nurse practitioner. Unlike Sandy, who periodically has on-site physicians who know the clients and the community, Andrea does not have a core group of physicians that is familiar with the community or has developed a working relationship with her to provide continuity of care for ongoing health concerns or during emergency situations. However, to provide Andrea and her colleague with consistent physician consultations, her employer has negotiated an on-call schedule with the physicians at the community health centre.

Andrea's employer is a community health centre in the urban community three hours away that provides health care in this rural community through a satellite service. There are nurse practitioners in the urban community health centre where their practice consists of regular office hours and no emergency service provision. Andrea notes how challenging it is for her rural practice to be recognized by her NP colleagues and the organization. From Andrea's perspective "unless you're in it, you don't really understand it; unless you've seen it, you don't understand it." Even though the organization is making some improvements through policies and physician consultation support, Andrea does not feel that she can rely on management as a resource.

While the lack of resources and support has challenged this experienced nurse practitioner she is able to use her skills and knowledge gained in remote NP practice in providing care for this community. From the perspective of maintaining

her own health, Andrea states the workload and the opportunity to leave the community on a regular basis helps to sustain her and prevent burnout. The community is fortunate to have such an experienced NP to provide health care services with so few resources - a situation where a brand new nurse practitioner likely would not have stayed in practice.

Robin

Of all the participants, Robin is the most comfortable and settled in her practice. She has been the nurse practitioner for this remote community for the past four years where she lives with her young family. In her interview, respect characterizes many aspects of the practice and relationships Robin has built. The relationship she has with her community began when she worked there as a new graduate Registered Nurse for two years as the only health care provider.

> When I graduated in 1995 this community was staffed by two physicians who both quit within a week of each other, leaving a void here. The organization was looking for someone to come here, but the nurses knew how isolated it was and what it involved, nobody would come. As a student I had done some of my practicums in the Intensive Care Unit and the manager there recommended me for the position. I had no nursing experience whatsoever, only nursing school. I was a new grad nurse in a community of 1,200 with a big clinic and no idea of what to be doing. My biggest friend was Bate's Assessment Book, and I used the telephone and I talked to the physicians and I did whatever I needed to do.

From the beginning of her nursing career Robin has developed her nursing skills at an advanced practice level because she was the only health care provider in a community that was used to receiving health care from physicians. What Robin takes for granted is the support she received from the physicians with whom she consulted on a regular basis as she was learning how to provide nursing care in an

isolated setting; learning on the job, case by case. From her willingness to learn and do whatever needed doing, the relationship that she developed with the community through her dedication to provide care likely laid the foundation of respect for her practice as a nurse practitioner.

Robin was in the first class of the NP diploma program in her province. When she returned to the community as a newly graduated nurse practitioner after a 2 year absence, she found she had to set up new relationships with her team members.

> It's different than when I was an RN, I have new functions and it took a little bit of getting used to on my part and on the part of my team, but things have come along quite well in the last 4 years.

Unlike other new nurse practitioners, the team that she works with in her new role already knew Robin. The physicians and other health care providers knew what kind of nurse she was, her skills, and her ability to work in an isolated practice. However, they needed to learn how to work with her in an expanded role with new responsibilities. Along with her new skill set, her practice has changed because of the changing demographics of community. From when she arrived, the population had declined by 50% to roughly 650 people. When the main employer closed, many young families moved leaving a mostly aging community with multi-system chronic conditions.

As a nurse practitioner, Robin is the highest level health care provider. At the time of the interview two other RNs worked in the clinic with Robin and a public health nurse. Until this past year, she had been the only acute health care provider. Her practice also extends beyond the community that she lives in. Robin provides health care to three other communities that she visits on a regular basis for non-

urgent health care issues and the clinic provides after hours/emergency care to all four communities. The communities are 1 to 3 hours away and the referral centre is 1 ½ hours away in good weather. So for Robin to travel to one of the other communities to see an acutely ill person and transfer them to the referral centre, it would mean being away from her community for a minimum of 6-6 ½ hours.

For non-urgent care the schedule at the clinic is similar to that of an outpost nursing station. There are set days for 15 minute appointments to address non-urgent health concerns; on these days Robin can see up to 24 patients. For "well women" visits, which include annual screening tests, appointments are 30 minutes. Robin has also set aside specific times for blood work and administrative work. Unlike other participants, Robin's practice is only within the walls of the clinic. The established operating structure keeps the clinic running efficiently; people know how and when to access services.

Robin has developed a working relationship with the community, a relationship built on respect. This has been gained by knowing the nurse practitioner as a person and seeing the NP role as part of the community. For Robin, the respect is mutual. The professional way she described clients throughout the interview reflected this respect. She called them gentleman or lady and did not give details other than those necessary to describe the health concern. This respect earned over the years also comes with expectations of being an integral part of the community.

> I always say it's a double-edged sword because they hold you to a high respect because you're their own. There's a lot expected of you. You're expected to be on the committees. And it's not something that people will come up to you and say you need to be on this committee, but when they come and ask you, you know if you don't, you lose a little bit of respect in the town. And because it's only 600 people you don't want to lose any type of

respect, any amount of respect in what you're able to keep here in this town. And if you break that respect, then you might as well pack your suitcase and leave right then and there because you're just not given a very easy time after that.

Her role as the highest level of health care provider gives her a certain status in the community that always has her in the eyes of the public. The trust and respect can be lost at any time. Robin's practice is at a place where some of the new NP participants are striving for; acceptance within the community and comfort and confidence in the delivery of health care services. Even so, in her every day practice Robin has to work at maintaining the relationships that she has built with clients and her health care team.

Summary

All of the participants faced challenges in establishing their practices in different rural and remote communities. As experienced nurses these NPs bring different knowledge and skills which shape their new NP practice such as women's health issues, team building skills, or emergency care services. The demographics of the community affect whether the NPs practice will include families, young children, and/or care of the older adult.

Other characteristics of a community that influence the NPs' practice include the economy and employment opportunities as well as the geographical location. Employment in resource based communities can fluctuate, altering the socioeconomic status and health issues for community members. Fluctuations in the population due to tourism or seasonal activities can have an impact on the overall workload of NPs. The distance to tertiary care centres and other medical support

services such as x-ray impact the type of emergency care services provided by some of the participants.

The physical location of the NPs' practice and the proximity of other health care providers also influence the development of the practice. Working in a clinic setting with physicians provides opportunities for collaboration in care services. For some participants their clinics are located within the hospital, providing additional networking opportunities. All of the new nurse practitioners have noted the importance of an on-site mentor to solidify their new advanced practice skills and build confidence for independent practice. When managerial or administrative personnel are not in the community to assist with the daily operations of the workplace, NPs take time from direct work with clients to incorporate these tasks into their work day.

Chapter Five: Establishing a New NP Practice

Starting a new job can be a challenging time. The newness of the NP role in

Canada has meant that the participants have had to strive to create a place within

the local health care system to provide care for clients. The participants' experiences

demonstrate that establishing a rural or remote NP practice is challenging and not

an easy process. They have had to work hard and overcome obstacles. It is

important in the early stages of developing their practice for the NPs to take time to

get to know the community. They rely on their RN skills as they further develop the

advanced practice skills needed to be a nurse practitioner. To develop their

practices they need material and human resources for guidance and structure.

There is a strong interplay between the resources available and the skills,

knowledge, and personality of the participants in establishing and building their

practices.

Working with people means that relationships grow and change, and the

shaping of the NP practice is a continual process. Robin, who has been practicing in

her community for a number of years, shares a wonderful story that demonstrates

the knowledge and relationships she has developed.

> This lady in a community that is 3 hours away from the hospital had
> been up to see the physician there that day with severe abdominal pain.
> She's a bigger lady, close to 400 pounds. It was a locum physician that saw
> her, said she had the stomach flu, and sent her home. She called me about
> 10:00 at night in severe pain, couldn't do anything about it. So I phoned him
> and I spoke to him and said, I think that this lady is in some serious pain down
> there and we need to get her up out of it and check her out. He said, "I saw
> her this afternoon and there was nothing wrong with her. I sent her home,
> that's all we can do for her. Tell her to drink lots of fluids, and take some
> Gravol if she gets sick."

> So I had to phone the lady back and told her what the physician said

and I told her to phone me again if she's not feeling comfortable. Well within the half-hour, she had called back again. And she was still very miserable, still throwing up and the pain had gotten worse in her side. I phoned the physician again, once again presented my case. I thought she was in severe pain and once again, I was refused. And I was not very pleased with him at that point because it was getting closer to midnight. And the thing about it I knew the lady was really sick because she's not somebody who presents to the clinic very much. And because she was an obese lady they couldn't do a real well abdominal examination on her and they passed it off as being nothing.

So once again I had to tell the lady the doctor is overriding me and says you can't come up. It wasn't, not even 15 minutes later that her husband phoned back and at that point in time she couldn't even move out of the bed anymore, her temperature was like 40 degrees Celsius, and she was really, really in what I thought to be trouble. So I said, "I may lose my job over this, but I may save your life in the meantime. What I'm going to do is instead of phoning my primary care physician, I'm going to phoned a physician at another hospital 3 ½ hours away and see if they will accept you and give me the OK to go down and get you." I phoned the hospital and the emergency doctor there at the time said "by all means go get this lady. She sounds like she's in trouble and bring her up."

I went and got her, it was the worst kind of a night. What usually takes 2 hours was over three to get there. In all these little communities when there's one person sick the whole community is up. When I got there at 3 o'clock in the morning half the community was waiting for me to get there. We had 24 men altogether, which is probably half the community of men. Unfortunately, she was on the second floor of a two-story home so we had to get her down the stairs, which were 20 steps and they were straight down. Her house was the very last one in the community, farthest away from the ferry as you could go. So twelve people would take turns, they would go so far as they could because it was wintertime and we had two or three feet of snow on the ground. So our stretcher wouldn't roll through the snow, you had to carry it. So you know, with that amount of weight you can only carry it may be 30 feet or so and you'd have to stop.

Anyway it took a good 5 hours to get her to an ambulance and I carried her straight to the hospital myself, which is another 3 ½ hours afterwards. So it took me all in all about 22 hours to get her into the hospital and for me to get back home again. When I got back home, there was a call from the surgeon. He wanted to advise me that she had a torsion bowel that had turned gangrenous, and if she had stayed in her community overnight, she would have been probably dead by morning. So it was at that point in time that I knew that I had done the right thing.

And I didn't lose my job over it, obviously, because I'm still here. But I did catch a bit of flack for overriding the physician. But on the same note she's still alive today. She weighs about 180 pounds now and she actually calls me her guardian angel. But I guess at that point in time if I hadn't acted on my own she would have been dead.

Robin's exemplar story illustrates how she uses her skills, knowledge, and the resources at hand in her practice. First of all, Robin knows the patient and the community well. From her history of working in the community she knows that this lady is not one to complain about her health unless it is necessary. Also by knowing her physique, Robin questions the completeness of the assessment done on an obese person. In knowing the person, and how she reacts to health concerns, Robin had doubts about the assessment of the situation made by the locum physician who had seen the patient earlier, who does not know the woman in the way that Robin knows her. She also knows the dynamics of a small community that comes together to help one of their own, even in the middle of a blustery winter night. So even though she was the only trained health care provider, she knew the community members were there to support her in providing the best care possible.

The skills that Robin developed over the years as a nurse practitioner coupled with her knowledge of this woman, made her realize the potential seriousness of the situation. While she was not able to diagnose a specific ailment, because of her experience, she went beyond her usual protocol by contacting a physician in a different hospital to try and get the care needed. The relationship that Robin built with the second physician is based on trust and respect for her skills and knowledge in advanced practice. A solid working relationship allowed Robin to be a strong advocate for providing emergency health care in this situation.

Getting to Know the Community

In Robin's story a key underpinning is her relationship with the community and how the community works together. The participants in the study who are starting their practice have taken the time to get to know the community and its people. By getting beneath the surface view of the community, getting to know what is available in the community, the people and their health concerns, the nurse practitioners can begin to understand the shape their practice may take.

How the NPs learn about their communities can happen in many ways. The participants who are involved in pilot projects for primary care have a bit of an advantage. Often times there has been a community assessment completed to support the need for a nurse practitioner. This baseline knowledge has been helpful as the NPs enter the building phase of their practices. Expectations about the type of practice needed for the community, the demographics of the community and its resources, and even to some extent, the expectations from the community were available to the NPs prior to beginning their practices. Even so, each nurse practitioner has taken the time to introduce themselves to the community and the community groups. Marion also includes the community in her annual reporting.

> What are the community needs, what research has there been done about the community. I know when the proposal was first made there was a great deal of research that went into looking at the type of illness that's here. The community was very much behind having a nurse practitioner here. They signed a petition to the Ministry of Health to have a nurse practitioner here, so I essentially reported back to the committee saying this is what a nurse practitioner does and this is what I specifically have done in the first year. (Marion)

Because of the involvement of the community in the development of the NPs'
positions, there is a certain sense of accountability to the community that is
pervasive throughout the interviews of those involved in pilot projects. In developing
their practice, the NPs need to be responsive not only to the needs of the other
health care providers, but also to the community members in general. Two of the
participants also did their own community needs assessment. This process was
helpful in three ways. One, the NPs learned about the various health care service
providers in their communities. Two, the various health care groups learned about
the potential role as the nurse practitioner. Three, the NP learned what the
community's expectations were for them. As Marion said,

> When I first came here I went out and met with community partners, and so I
> met with people like the preschool speech and language program, district
> health program. I met with the women's shelter, the director that does
> placement for seniors. I participate on a number of coalitions; the Heart
> Health and Healthy Babies-Healthy Children. So that the community would
> know, who I am and what I am and what I can offer. I met with the local
> newspaper, the press. Somehow getting connected with the community,
> presenting yourself, finding out about the programs that are being offered and
> by whom. It's really knowing your community and having the community know
> you. (Marion)

Marion did a lot of public relations work in the beginning of her practice to
learn about her community and to have the community groups learn about the NP
role. The connections she made showed the breadth of her practice from babies to
seniors and gave her visibility in the community for health promotion endeavors. Her
community involvement demonstrated to the community that health promotion is an
aspect of care provided by a nurse practitioner.

Getting to know the community extends beyond learning about community
resources and how the role of a nurse practitioner can best suit the community. It

includes learning about the economic environment, how health care services are

accessed, and why. The NPs who have lived and worked in their communities for a

number of years, particularly in more remote communities with limited resources,

have experienced how the economy of the community has a profound impact on the

nature of their practice.

The high rate of unemployment and the higher proportion of older residents in

her community have affected Robin's practice by increasing the workload but not

necessarily the acuity.

> Right now, my most challenging thing is finding enough hours in a workday to
> do everything that needs to be done. Really and truly, with only 650 people
> here, we should not be fully booked every day but I am. And I blame that on
> the fact that people at one time did not have time to sit home and wonder why
> their finger was hurting today. But now they can sit home and say well, you
> know, that fingers been hurting for two weeks, I think I'll go up and see what
> that's all about. (Robin)

The appropriate use of health care services can be a challenge when people

have time on their hands. The increase in patient visits means that Robin does

administrative work after hours rather than during regular clinic hours. A seasonal,

tourist economy also can affect service expectations. In Andrea's community, some

of the residents expect more services than she can provide in a remote community.

> What I find hard are the people that come up for the summer, because they
> have camps there and they expect the same type of service that they would
> get in an urban center. And they become very demanding that way. They
> don't realize that if you choose to live in an isolated area, there's some risks
> involved in that and we are providing a service to the best of our ability, but
> it's not the same service that you get in the urban center. I think we're
> providing a really good basic service to them, but we can't bring an x-ray
> machine up to the community and we can't bring lab techs up to the
> community. So that can be a bit difficult. (Andrea)

In terms of community expectations, Andrea is the only one who speaks about the differences in health care delivery in a rural setting versus an urban setting. Some participants speak to this issue but from the other side of the coin in terms of what they are able to provide for care, particularly in an emergency, and the limitations placed on that care because of the distance from tertiary care and resources available.

Providing health care services in communities with few resources becomes an even greater challenge when there is increased use of the existing services. The nurse practitioners in these communities run the risk of burning out. Andrea's scheduled time off in the city gives her a reprieve from the community and influences the relationships she has with clients and the community in general. Andrea views herself as an outsider but sees the benefits of that status as clients are more willing to share information with her.

> Being an outsider, you get a real feel for the community, what's going on in the community. You sort of know what the heartbeat of the community is. I think it's good to be an outsider, because I think people feel comfortable. It's a small town so word gets around really quick, so if you're an outsider they can come to you and talk about whatever is bothering them. If you were a member of the community and trying to do this job, it would be difficult because I think people would have a harder time opening up. (Andrea)

Andrea has worked in the community for the past 3 years, which has led to gaining the trust of community members. Because she leaves the community on her days off, in her own eyes she is not a member of the community; she is more of an informed and trusted outsider.

Getting to know the community is multifaceted. On the surface learning about the community resources and demographics of the people will provide the NPs with

some information about how their practices might best serve the community. Underneath, are the beginnings of developing relationships with resource groups and individuals within the community to determine how the NP as a provider and a member of the community will fit in.

Honing Skills as a Nurse Practitioner

These nurse practitioners need the skills and knowledge to create a practice that focuses on the health care needs of the community. All of the participants have had many years of experience in nursing. The skills developed over the years enhance their NP practice and for those that are new NPs, provide a solid base on which to build their advanced practice. These nurse practitioners, as the only nurse practitioner in their communities, have limited mentorship and continuing education opportunities. They depend on the availability and willingness of physicians and other NPs for support as they hone their skills as nurse practitioners.

Consolidating New Knowledge into Everyday Practice

Communication skills and the ability to connect with clients, along with previous work experience, give the participants confidence and expertise in areas of their practice while they are still novices with the nurse practitioner skills. It takes time and energy to incorporate new knowledge and skills into care provided for clients. The skills developed over years of RN practice that they bring to their NP practice are taken for granted by these NPs. Keeping nursing as the framework for providing care can be a challenge when practitioners focus on assimilating medical care into practice.

> Right now some of my challenges are making sure that I'm not missing things and that I'm giving sound advice, because part of my practice is medicine. I

feel fairly comfortable in the nursing aspect of my practice, I feel like an expert there, and I don't question things that I do that are related to that, but when it comes to diagnosing and illness, I get caught up a little bit in the medical model. I find that hard, breaking people down and communicating it in a medical sense. So I think we are sort of cautious that we make sure that we're balancing the nursing as well as the medical. (Marion)

The care provided by a nurse practitioner is situated between the care of a

Registered Nurse and the care provided by a physician, incorporating practices such

as diagnosing, prescribing, and development of treatment plans usually performed

by physicians. Over time the practitioners incorporate newly learned skills into their

practice, spending less time and energy thinking to process the knowledge.

And a lot of stuff now is becoming a bit more second nature to me now. So when I was a nurse clinician I knew my job, so I kind of lived that. And I wasn't really thinking about it a lot. And I'm starting to get that way now, being a nurse practitioner. I was always so tired at the beginning, because I had to think all the time, that's the hardest part when you first start. You have to do so much thinking it's mentally draining, because you have to assimilate all the information that you've learned in school. So that's pretty difficult to do and it takes time. So to just get into a practice where you have that support and mentors to help you through, really can get you going in the right direction. And it starts to get less and less scary! (Sandy)

In their interviews the participants revealed how they have learned to build

their practice over time as they consolidate new knowledge into their daily work. As

they gain confidence in their advanced practice, the NPs' focus of energy shifted

from the development of their own abilities to the care needs of their clients.

The NPs, some of whom come from an acute care background, talked about

how they had to integrate a different approach to their practice and resolving client

concerns. In a primary health care practice, many of the health care issues are of a

non-urgent nature; there is time to work with the client, to assess the client, and

come to a diagnosis. The more experienced nurse practitioners, like Robin, have

learned to have confidence in their skills and have learned that there is time in

practice to call upon that knowledge.

> And sometimes when I get into a situation now where I say, my goodness, I don't know what's going on with this patient. I'm really confused over this-I have no idea. I remember what my mentor said, 'take your time, figure it out, you've got lots of time. The patient's had it for two months; they're not in any dire straight. You've got some time to figure it out.' And there's been many times that that's kept me from having a couple of headaches for sure. (Robin)

Throughout their practices, there will be times that the answers to a health

issue will not be readily apparent and novice NPs have to develop a comfort level

with not always having the answers right away. For newly graduated nurse

practitioners, knowing the limitations of their knowledge and skills and working within

it is an ongoing challenge particularly in practice settings with limited mentorship or

supervision.

> You have to know your limitations and seek help when you're beyond what you can do. Like you have to really recognize where your skills are and where they stop, because here I'm pretty well given free rein. If I wanted to do almost anything, like, no one's there to stop me- and that's a scary thought. You have to be responsible because there's no one looking over you, like no one who is supervising you, you have to supervise yourself. When you start a new position there's usually someone to guide you, to show you the ropes. I don't have that, I don't have a supervisor. I'm in here blind. And I have to make the decision on my own, is this a situation where I should consult with somebody or can I deal with this on my own? And I have to constantly make that decision. That's what I find most challenging. (Barbara)

Barbara talks about the responsibility as a new nurse practitioner working in a

setting with limited opportunity to learn from another nurse practitioner or someone

who is knowledgeable about NP practice. To know the scope of practice for nurse

practitioners and to assess when to seek guidance adds to the stress and mental

drain of starting a new practice.

When an experienced nurse practitioner starts a new practice, previous work experiences enhance their confidence with advanced clinical skills. The NP gains the confidence to explore health issues in more depth with clients, maintaining the balance between the medical and nursing aspects of practice.

> This woman had seen a physician, been put on antidepressants and on stress leave for a couple of weeks, who said 'gee, you know, have you had a Pap smear and stuff, why don't you go and see Theresa?' So she came to see me and we talked a little bit about what was going on in her life and stress. We found that she was an adult survivor of sexual abuse. Now, I have a lot of experience with that, from my practice in the north and being chair of the sexual assault committee up in one of the communities that I worked in for a number of years. And so I was able to see some of the characteristic stuff that goes on and able to ask the right questions to get her to reach the point where she was able to feel comfortable enough to say this. Then I was able to take this back to the doc and say, listen, there's a lot more under the surface than meets they eye and do you know much about what happens with women who are adult survivors that are coping, especially in their 30s? There seems to be some typical things that go on in their lives. So I was able to make a difference to her in terms of let's work on some of this stuff. Let's put you together maybe with somebody who can help you. (Theresa)

The skills of this experienced nurse practitioner benefit not only her clients but also the health care team that she works with. In a subtle way she mentions the quick teaching moment that she had with the physician explaining the long-term effects of abuse on women. The time taken with the client, who came to her for a specific medical procedure, and how she used her nursing knowledge and communication skills to uncover a more complex health care concern, shows how this NP implements her advanced practice.

When new nurse practitioners take the time early in the development of their practice to consolidate their knowledge, assessment, diagnostic, and treatment skills they are able to gain confidence as an NP and move forward in developing their

practice. While this is something the individual NP has to do on their own, it is helpful to have a mentor to support this learning process.

Mentoring and Support for Skill Development

Having other health care team members to help new nurse practitioners hone their advanced practice skills is important to the development of their independent practice and finding their place within the health care team. The people available to support and mentor the new nurse practitioners vary with their work settings. While some participants would have preferred to have another nurse practitioner as a mentor for skill and role development, in the absence of experienced nurse practitioner colleagues in the workplace many have developed mentor relationships with physicians. Establishing connections with other nurse practitioners in the region has been beneficial for role and skill development as well as decreasing the feeling of being the only and the lonely nurse practitioner.

Relationships with other nurse practitioners. The development of relationships with other nurse practitioners is an important support system for the participants. The nurse practitioner colleague who Andrea job shares with is her main support for her practice as she is "in the exact same boat that I'm in." Others in the study find support from NPs in similar work situations, particularly those in communities that have not had previous exposure to nurse practitioners. In the absence of an NP mentor on site, the nurse practitioners use each other as clinical resources to bounce ideas off and to problem solve cases. This occurs both during working hours and after hours.

I got us together so that we can phone each other and not necessarily rely on trying to find that information out on our own, when we have questions. So we formalized it to the degree where if somebody calls, if it's a nurse practitioner, I'll take that call. They can interrupt me with a client because sometimes they're out in a rural community and they have a question and they don't have a book on hand and there's no physician there and so sometimes we're the only line of support to each other in a situation like that. (Marion)

The willingness to interrupt care with clients to support a nurse practitioner colleague highlights the value and importance of the relationships with other NPs in rural and remote clinical settings. Knowing that there is always going to be someone at the other end of the telephone helps the NP to feel less isolated in their practice, and to be more effective in their practice in a timely manner. The connection with other NPs is vital to sharing limited time and resources and moving nurse practitioners ahead in defining their role.

NPs living in a resource-limited rural community need to be creative in seeking and obtaining continuing education. For example, not only have Marion and other NPs in the region formed an informal group, meeting during work time on a regular basis they also organize their own continuing education in the absence of available, appropriate opportunities.

I've organized the local nurse practitioners here, I'm not the only one. We meet on a monthly basis to either share things like development of medical directives, to share any reading of new information, new clinical practice guidelines, to problem solve, to complain, to have lunch, and to try and figure out what some of our common learning needs are and set things up that are going to meet our learning needs. For instance, later this month we're going go see an ophthalmologist so that we can bone up on our eye exams. Another time we had somebody from the provincial breast-screening program, one of the physicians, coming to speak to us about what they're doing, the types of patients they want to see, and which ones are appropriate to refer, which ones are appropriate not to refer. (Marion)

Gaining experience and building on knowledge is important to Marion. One of

the challenges of being in a rural setting is advancing her knowledge in certain areas

for her practice. Marion shows her leadership skills by the connections she has

made with the other NPs in the area and the education opportunities they have

created for themselves.

For other participants, issues at the provincial level have been the impetus for

collaborating with other nurse practitioners. Nurse practitioners are a relatively new

care provider in most provinces and because there are so few of them, they need to

support each other not only as individuals in practice but also as a branch of the

nursing profession.

> There's only 39 of us. The first two classes, my own class and the next class I
> pretty much know them all personally. When there's an issue pertaining to a
> particular nurse practitioner within an organization or at a provincial level, if
> they need support or if they need letter writing or if they need lobbying or
> whatever, our group does it for them. There's no question there. Again as
> long as it's not detrimental to the reputation and the initiative of the nurse
> practitioner in our province. (Robin)

The relationships that the participants have built with other NPs are not only

sustaining them in their practices but also helping them to grow as a profession.

Receiving support from others who have complete acceptance and understanding of

the potential for NP practice is important to the participants. For many new nurse

practitioners, support from NP colleagues at a distance for practice development

complements the support of skill development by local physicians.

Physicians as mentors. In the absence of fellow nurse practitioners as

mentors, the participants have relied on physicians to provide guidance in

developing and consolidating their clinical skills. Establishing a mentoring

relationship with at least one physician with whom they work closely has been critical

for the new NPs to the early development of their practice. Sandy has felt supported

in her developing practice by a physician, who became her mentor while working in

the community three days a week.

> He never gives me the axe or is dehumanizing or hypercritical. He can always
> turn it around and make it as a learning experience, so it's like reframing the
> whole thing. I might feel terrible because I think I've missed something
> essential, but he just sort of allays my fears and says 'don't worry, you've
> learned from this, so next time it'll be better.' (Sandy).

Sandy's relationship with her physician mentor is a positive and supportive

one that is helping her to build confidence in her practice while she is improving her

diagnostic skills. What is implied is the acceptance by the physician of the NP role in

the community. The acceptance of the NP as a member of the local health care

team is an important part of supporting the new nurse practitioner, and when that

support is absent or limited, the development of the NP's skills and practice are

hindered.

Marion's situation is an example of the influence of local policy and personal

dynamics on the support she receives. This challenges the development of a

collaborative practice where "the time is best spent with the right care provider" -

Marion's motto for practice. Two of the physicians in Marion's clinic have been

supportive of the Nurse Practitioner role and in the past were willing to mentor her

and assist her to expand her practice to include emergency care. The recruitment of

three new physicians to the practice has changed this working relationship. The

physicians have concentrated on building working relationships amongst

themselves, working out the kinks of personalities, and sharing a business together. Marion no longer feels part of the care provider team.

> When we first worked together I would have to either wait outside their door until they'd finished seeing their patient, or call in and interrupt them because I had a question. They felt like this was interrupting their practice, which I didn't like the language, but that's the wording they used. (Marion)

The physician team delegated one physician to be a contact person for her to discuss her practice issues and to bring forward practice concerns to the others. While this is an improvement in terms of time management for consolidating her clinical skills, they are limiting her ability to grow in her practice through clinic-based medical directives.

> They're either not ready for that level of practice because they don't know me yet, but on the other hand there isn't a process where I'm included in that process for them to get to know my decision making. (Marion)

Marion has identified that in order for her to move forward as a nurse practitioner, she needs to continue to build her relationships with the clinic physicians so that they get to know her and her skills.

Having a physician mentor is important in the consolidating and honing of advanced practice skills, particularly the skills that have traditionally been in the medical domain of health care. A benefit of this relationship can be physicians developing an understanding of the NP practice and how it is complementary to their own practice. While a mentorship relationship may assist the NP in skill development, the dynamics of the work environment may limit mentoring in the development of a clinical practice and integration into the health care team. Mentoring and support of NP practice is particularly challenging when there are limited health care providers in the community.

Support when you work alone. Two of the participants in the study are the most highly qualified health care providers in their communities and deal with emergencies in their practice. These two experienced nurse practitioners, who have confidence in their advanced practice skills, acknowledge the importance of having someone to trouble shoot with and share the workload that they do not have when they are working alone.

> The RNs that work with me have enough experience that they have a good idea of what's going on as well. And you can always bounce something off of them for their opinion. And the receptionist who has been here for 17 years, she would help me. She knows what every piece of equipment is called, she may not be able to get it by name but if I describe it a little bit she can get it for me. And she'll call the physician for me and get him on the speakerphone and that's where I get my assistance when there's no other nurse here. But when you are on your own, you are definitely on your own. We have a physician that is available by telephone only but they can't see the patient. (Robin)

Robin may provide the highest level of care for her community but the practical assistance that she gets from the receptionist as well as the ability to troubleshoot with other RNs helps to lessen the stress of an emergency situation. In addition, the ability to consult with a physician at her referral hospital provides support from a distance for the care of individuals. Andrea on the other hand has limited support both locally and at a distance.

> Being available for emergencies is very challenging, just being there by myself and having to determine what is wrong with the patient and anticipate potential problems and be prepared for them. Hopefully with the doctor on the phone, if I can access him, if he's around to give me some guidance. Stabilizing the patient, doing IVs or catheters or NG tubes, I'm by myself doing that because the two ambulance attendants are level 1 so they are limited in what they can do. And then waiting for the plane or helicopter to come, the least time is an hour but most of the time we have to wait longer. I've had some really sick people that left the community and never came

back, but I was able to at least keep them as stable as possible while they were in the community. (Andrea)

Support from physicians at a distance decreases the physical and mental demands of providing emergency care with limited human resources. This support assists the NP to provide the best care possible given the circumstances.

Nurse practitioners need support and mentorship throughout the development of their practices. New NPs benefit from hands on supervision as they incorporate their advanced practice skills and knowledge into their care. As the only NP and sometimes as the highest level of care provider in the community, support for clinical decision-making is important to the sustainability of the NPs in their practices.

Resources for Developing NP Practice

Not only do nurse practitioners need to know their communities and have the skills to shape their practice, they also need the right resources. For nurse practitioners items such as office space, equipment, written policies, and procedures are practical resources used to build their practice. The amount of time spent working influences the development of the NPs' practice as well as their welfare. The relationships built with the different people that the NPs works with in their everyday practice are important. The NPs' communication skills influence the establishment of different relationships as well as how those relationships develop and change over time.

Adequacy of Resources

The material resources available vary with each NP. In the interviews, the participants do not express concerns about material resources such as office space and equipment for their practice. Those who are in pilot projects have mostly new

equipment and the other participants have what they need to be able to practice at a safe level in their communities, particularly those that provide emergency care.

Underpinning the development of NP practice is how their role fits into the health care system through the governance of practice at the local and provincial level. Provincial legislation determines the scope of practice for NPs. The incorporation of nurse practitioners prior to completion of local policies and procedures to support their practice has meant that many of the participants have been creating the policies themselves to identify the practice parameters for their particular setting.

Legislation influences on scope of practice. The participants discussed two areas of their practice directly influenced by legislation: prescribing medications and referrals to medical specialists. In some of the provinces, implementation of nurse practitioner positions occurred prior to legislation giving NPs prescriptive authority. In those provinces, a nurse practitioner had to consult with a physician and have that physician fill out the prescription. This hindered the development and time management for two of the participants' practice.

For other participants who have prescriptive authority, the constraints on their practices relate to the kinds of medications they can prescribe. Some NPs are able to adjust their specific list of approved medications at the local level based on the approval of the physicians working in conjunction with the nurse practitioner. In Marion's experience, this process can constrain the NP's practice when the physicians are not ready to recognize her scope of practice and integrate her role into the local health care system.

I would like to have a little more leeway in terms of reordering medications. I really feel that there's a lot of control that goes on in terms of medication renewals. If somebody's had high blood pressure and it's been stable, I proposed a medical directive that would allow me to reorder stable chronic medications where the patient had demonstrated control both in blood pressure, in laboratory findings, in understanding of the disease and in follow up, that I could renew that prescription. They didn't buy it. So now, the same thing happens. Patients go to Emergency because they can't get an appointment with the doctor to get them refilled, or because they're senior, they just forgot, and they didn't realize that their prescription was running out. Now they have to wait in a four-hour, six hour, or eight hour Emergency line to get a prescription renewed. It's not good use of Emergency service time. So I really feel in terms of helping patients, that I had a role that I could have made a bit of a difference there, but that's not happening. There are women on hormone therapy that aren't sick, they just want to prevent bone loss, and I can't renew their prescription. There are people that I teach how to use asthma puffers that come in, their asthma has been in control, and they just need a puffer renewed before they go back to school and have to go to gym class, and I can't do it. So things that we can manage and have a fair degree of skill and knowledge about managing - we can't just go that extra distance. In some practices the NPs could, but it's not consistent. (Marion)

The understanding and willingness of the physicians in the community to work in collaboration with Marion directly affects her ability to build a practice that meets the needs of the community.

The referral process for specialized medical care is another area where legislation limits NP practice. In order to refer their clients to a specialist, provincial legislation required several of the NPs in the study to first refer them to a general practitioner. The general practitioner then refers the client to the specialist, creating a two step process. There is the potential to increase the workload for general practitioners and in communities with a shortage of physicians; there could be a delay in the client receiving appropriate health care.

The legislation has been a bit of something to deal with. Currently when I want to refer to a specialist, such as an obstetrician/gynecologist, there is nothing in their current fee reimbursement schedule that makes them happy about accepting a referral from a nurse practitioner. So the current route is

usually refer to a physician who then gets to bill for that referral and then they will send the patient on to a specialist who will then bill for that. Because there's a discrepancy in the fee, there's no incentive to take referrals from nurse practitioners in this province. I can't manage my own patients fully. If I want them, as a new diabetic, to go and see an ophthalmologist for a dilated eye exam, they won't accept my referral. So there are some doctors that just flatly refuse, so you always have to have a physician cosign your referral. And they don't really want to do that because then the follow up notes from the specialist come back to the physician and by right of having that in front of them, they have to deal with it. (Marion)

Nurse practitioners view referrals to other health care providers such as medical specialists as being within the scope of their practice, particularly for disease prevention and screening examinations.

Nurse practitioners work within the boundaries of legislation to develop their practice, even when they could provide more efficient and effective health services. Legislation allowing NPs to practice to their full scope of practice is an evolving process and vital to the integration of the NP role into the health care system.

Local policies. Many of the participants began working prior to having policies and procedures in place to support and structure their practices. This has created both challenges and opportunities for individual participants. The NPs reported how they increased their efficiency by collaborating with other NPs on protocols, policies, and documentation.

So the three of us nurse practitioners and we're in three different communities in our region, have been supporting each other, and trying to get together on a regular basis. We want to get procedures, written protocols going for our role, because there's nothing. We're starting with nothing. And we don't even have a written delegation of function policy with our physicians, which we really should have. Because a lot of what we do since it's not regulated yet, we're technically going out of our scope of nursing practice, so we need to work within a delegation of function role. So my support has mostly been from the two other nurses working in this role in the region. (Barbara)

A challenge for Barbara and her colleagues is working without written guidelines and policies in place. Working together to create protocols and policies is an opportunity to work efficiently and provides support for the development of rural NP practice.

Limited access to current literature to support her practice led Theresa to create unique opportunities for pursuing evidence based practice and extend relationships to include other health care providers.

> I am also championing the whole area around evidence-based practice and clinical practice guidelines so it's my job to actually make sure that all the groups receive sort of the latest and greatest around those initiatives. And also, then, to make sure, once they start putting the programs together, that we are true to the whole idea of being evidence based.

> I'm maintaining a resource library for the doctors. One of the barriers was that I don't as a nurse practitioner get literature on stuff. So I have to dig all the time. So what I did was I started a service for the doctors. They get like a myriad of free magazines, all the stuff that I need to keep current. I'll provide a library if someone will start bringing their magazines to me and I'll keep up a library for you, and of course, I'm also keeping up clinical practice guidelines. (Theresa)

As a champion for interdisciplinary evidenced based practice, Theresa thinks of creative solutions to work around barriers to developing her practice including the lack of local protocols and the inability to access appropriate resources.

To support their practice, nurse practitioners need regulations at the local, provincial, and national level that recognize the place of the nurse practitioner in the health care system. When they are not available, these nurse practitioners are spending time developing policies and procedures instead of focusing on delivery of health care services.

Time to Practice

Time is important in the development of NP practice. Not only is time needed

to get to know the community and for new NPs to consolidate their skills, the longer

appointment times that NPs have with their clients shapes their practice and

relationships with individuals. However, when NPs in severely under-serviced

communities are working too many hours in a day, it can be detrimental to their

health and well being.

The amount of time that many of the participants are able to spend with

individual clients relates to the quality and kind of care they can provide. The NP's

communication skills and the time spent with clients improves care as noted in

Theresa's earlier story of the woman on antidepressants who is an adult survivor of

sexual abuse.

> I find out things because I'm able to spend time. There are the big dramatic
> things, but then there's the more simple things around just how am I
> supposed to eat and what does this high cholesterol thing really mean? And
> those are the things that are meaningful for people, to be able to talk about
> these types of issues. (Theresa)

In many of the rural and remote communities, the nurse practitioners provide

women's health services. The longer appointment time spent with clients is

important to building the relationship, incorporating health promotion and prevention

education as well as physical screening procedures. For many of the NPs, this part

of their practice provides the greatest satisfaction as they are providing a much-

needed service, and they get a lot of positive feedback. As Barbara noted, "quite a

few women have said that I've given them the most complete physical they've ever

had in their life. And that's because of the time I spend with them. I think that's so important."

Taking time to work with clients is important but also important is taking time to ensure the health of the NP. What all of the NPs share in common is that they are practicing in communities that are under-serviced for health care. Even if there are physicians available in the community, the supply is insufficient to meet the demands. For the three nurse practitioners working as the highest level of health care provider in their community, when asked what is most challenging in your practice the response was "not enough time." These participants talk about the need to protect their time in regards to the amount and the acuity of work. The NPs experience a lot of responsibility as the main service provider. If they don't provide the care, the community goes without.

> Last year I had 300 overtime hours. So, it could be endless. I could be there seven days a week, ten hours a day, and it still wouldn't be enough service. This year I have to protect the time away from the clinic as my own. Sometimes you get a little bit of griping, even though we put signs on the door well ahead of time, we give people plenty of notice when we're not going to be there, because there's no service that you can get. It's overwhelming sometimes that way because there's never an end to the work. (Sandy)

The focus of Sandy's practice is to be available to provide health care services to the community, at a time and place that best suits the individual. Even when she tries to take care of her own health by ensuring adequate time away from work, Sandy feels the emotional burden of the continual needs of the community. The provision of primary health care services, including health promotion and disease prevention is never ending, and the NPs experience challenges in pacing themselves and maintaining a balance between work and personal time.

> When I'm alone here I have to work on what I can do. I'm a bit of a workaholic anyway so I will work day and night if somebody doesn't stop me. But fortunately I have a partner who's well grounded and will say to me 'you've worked for 12 hours a day and you've been in transport for six of those, I think it's time you go on to bed and forget about patients. And if there's an emergency, they'll call you. Other than that the other stuff can wait till tomorrow.' I know sometimes people expect more of me that I can do but again, I'm only human and there are only so many hours in a day I can go without physically getting ill myself. There have been times I've worked eight weeks without a day or a night off. If I'm not working at the clinic then I'm on call. And we do have a fairly busy call out here. It can take its toll after awhile, working day, and night. (Robin)

Nurse practitioners who practice alone and whose practice includes

emergency care, have a huge responsibility for the health and welfare of the people

in the community. To always be 'the nurse', ready to respond to an emergency

situation can overwhelm the individual practitioner to the point of physical and

emotional exhaustion. The demands of providing 24-hour emergency services

depend on the acuity and frequency of the health care needs.

> Now the pace isn't really super busy. If it were, I think the burnout would be quite high. And that's why I left the north, was because I worked in really busy nursing stations, and busy after hour call and I did a lot of call. And then the social problems, it just burns you out. So this community is a very manageable community because the pace isn't super busy, but just busy enough. The after hour calls aren't overwhelming so I don't feel that I would burn out really fast. (Andrea)

There is a fine balance between coping with being the sole highest level of

care provider, the acuity, and volume of work. All three participants who serve as the

highest level of health care in their communities, are working in settings where they

do not have a supervisor or administrative person on site to oversee their practices.

It is up to them to pace themselves, and say 'no' when needed so they can ensure

the provision of care while maintaining their own health and fitness to practice.

How NPs use their time is as important as the period of time it takes to shape their practice. The benefits of the time spent with clients providing health care to under-serviced communities needs to be balanced with the NPs' needs for their own health and well being. As new nurse practitioners build their practices, the relationships forged with other colleagues in the provision of health services can be a factor in time management for health care delivery.

Relationships with Team Members

Nurse practitioners work with others in the provision of care. The working relationships with team members, particularly the office staff and physicians, are important for the development of the NP practice. Fundamental to the development of relationships is an understanding and respect for the work that each team member contributes to the delivery of health care.

Office personnel. For some of the participants, office personnel have had to learn how the NP role is different from other RNs working in the clinic. The NP needs administrative support similar to that of a physician because of the nature of their advanced practice.

> It was hard inroads when I was first here. I was the new kid in the doctor's office and the front staff were not willing to do anything for me because I'm not a doctor. And it was really hard because I'm a nurse, that's what they see me as, a nurse, and they don't see me as someone who needs that clerical support and the other types of support. That's changing over time because it's part of their routine. But you have people who have literally worked here for 20 years this is the way we do things, this is the way we always do things. And it's hard to change. (Theresa)

Theresa is working in an established clinic, where routines and roles for the nurses and doctors were understood. She had to find new ways of working with the office staff to incorporate clerical support for her NP practice. When this support is

not available or providing that support is not a part of the staff member's role, then the nurse practitioner must use their time to do non-nursing tasks.

> In the proposal funding for my position, the budget for support staff was not funded. So that's a real bone of contention because it means I have to do a lot of data entry to generate my quarterly reports by myself. I have a medical secretary but she works for the docs. The medical secretary is there to book appointments, to sign in clients, to protect me from the onslaught at the front door and she does a really good job. And we're really lucky in that the medical secretary has been there a long time, so she has a real flavor for the families that come to the clinic, and also has prior history, which is very important when you live in a small rural area, you have to make the connections in families. (Sandy)

The secretarial support that NPs receive is beneficial not only in relation to the administrative work, but also there is the benefit of working with someone who knows the people of the community. Many of the participants spoke about the gatekeeper role the office staff plays in controlling the appointments and protecting the NP's time. Office support is essential to the NP so that they can best utilize their time with providing care rather than administrative work.

Physicians. The ability of the participants to provide appropriate care to clients and establish their practices successfully hinges on the relationships that they develop with physicians. What physicians are to NPs is multifaceted: mentor, collaborating practitioner, consultant, and in some work settings, referring specialist. In caring for their clients NPs build relationships with physicians they work with on a daily basis as well as those within and outside of the community. Understanding of the NP role and its complementary nature to a physician's practice are key pieces to building relationships with physicians.

Sandy shares an experience that highlights how politics can hinder the integration of NP practice in the local health care system. Sandy provided wound care management for a client in her community on a bad weather weekend to save the woman a trip into the next town to see her physician. As part of communicating the care provided, Sandy wrote the client's physician a summary of her assessment and treatment. The physician was not happy that a nurse practitioner provided the health care. He phoned to tell her:

> It wasn't me personally and that probably I was providing very good care, but in this political environment he was just not willing to work with nurse practitioners until push comes to shove. I think it took a lot for him to actually call and apologize, but in this day and age when you don't have physicians to care for all the people in your community, you have to chill out and accept help as it's offered. It wasn't that I was stealing his patient but I was providing access to service. So it was kind of a double- edged sword. I appreciated his apology, but just to say politically that you're not in favor of nurse practitioners, didn't seem to me that he had very much insight about what actually is involved in the professional competency of nurse practitioners. So he needs a bit of work! (Sandy)

Working in collaboration with NPs and sharing the care of clients, is a challenge for some physicians, who may be concerned with a possible loss of revenue or control over the care their clients receive. Sandy's approach to this physician, "he needs a bit of work" reflects her positive outlook and her conviction that with more understanding of an NP's practice that this physician may come to understand how her practice can be complementary. Collaboration in practice develops when there is an understanding of the kind of care the NP provides, particularly when the physician is able to see the benefits to their workload.

> You know, they're still getting to know the role, from my point of view, but it's developing more of a trusting relationship so he kind of knows my boundaries. He can hand off more stuff to me now and I feel comfortable with that,

knowing that we still touch base to update on the patient's condition so that's good. It keeps me challenged all the time and gives him a break. (Sandy)

The extent of the collaboration in practice varies. Sandy separates the work she does with clients as: "I have my own caseload where people see me primarily, but then I kind of baby-sit or monitor the patients in the physician practices." This gives the impression that she is monitoring the physicians' patients because the physicians are not in the community to do so themselves, rather than looking at her practice as complementary. Her comments suggest a service to the physicians as well as a service to the people of the community instead of a collaboration based on trust and respect for the skills of the nurse practitioner.

Participants who have had many years experience as nurse practitioners, build relationships with the physicians in ways that vary with the physician's previous experience with nurse practitioners. Theresa hardly mentions her relationship with the clinic physicians. She knows she has their respect because of her vast outpost clinical skills, which are beyond the skills needed for current practice, and because the physicians have worked previously with outpost nurses.

Andrea has had the most difficulty developing relationships with the physicians in her practice because they have not worked with nurses in advanced practice roles. This has been the most problematic part of her job. She was used to working in northern health centres where the working relationships and protocols for consultation were established, and, for the most part, functioned well.

> When I first got there, I was pretty much on my own, because I wasn't really getting the physician support. We weren't really sure who to call, if we were to call the hospital and talk to the doctors there. And I've had doctors refuse to take my call while I was in the midst of dealing with an urgent matter. And then the doctors that worked for the centre weren't really aware of what the

nurse practitioner role was and they thought that they were liable if they were giving advice over the phone for a patient they had no contact with, so they were really hesitant to do that. They've worked with the nurse practitioners now for a couple of years so they're very, very comfortable with the role. And so they're not hesitant any more to do that. But that was all a process. (Andrea)

Physician support for nurse practitioners working alone is a challenge when the physicians lack familiarity in working with an NP, particularly in emergency situations. There is a process of establishing trust as well as an understanding of roles and responsibilities.

The development of a working relationship with physicians takes time. Robin's experiences with the physicians that she works most closely with show a level of collegiality other nurse practitioners strive for in their practice.

> I think because you have to build a reputation with these physicians as well, you can't just expect it. And I know I was only new to practice and nobody knew who I was or... But now, even to say that nobody knew who I was, even with the physician community that we have, specialist and within the nursing community itself, I'm fairly well known now. I mean, we only have, if you take the whole area and add them altogether, we only have 55,000 people, you know, with the whole western portion of our province. So it doesn't take very long to become well known. So I don't really have that problem with specialists now. I can phone any specialist I want to and in fact, I've attended a lot of meetings and things and I know most of them by first names and I can pick up the phone and phone them and if I voice my concerns they will more than likely be more accommodating now. (Robin)

Robin's use of "we" invokes a team caring for the patient, whether that is the NP and physician as well as the other RNs in the clinic. Her clinical skills have garnered respect from physicians. What is so positive is that Robin gets feedback from the physicians so that she is aware of their respect.

> In actual fact, the internist wrote me a letter the week after and said that the lady was very lucky. Because she was basically sitting on my doorstep and as soon as she walked in the door she swallowed two aspirins

right away. That's what he contributed to probably preventing the damage to the heart that could have happened.

So anyway, that was a bit disturbing that I may have missed something in my diagnosis the night before. And I spent most of the morning just thinking about it and a little bit a, a little bit perturbed. But anyway when I went home for lunch at 1:00 my emergency phone rang and it was the physician calling me back saying that oops, I made a mistake, you were right. I had it backwards with the x-ray. With the coloring of the x-ray, light means air and dark means consolidation. Or vice versa, I think it is. Anyway, he had it backwards in his own head and actually, I was right in the first place. It was viral pleurisy that the boy had and not a pneumothorax. (Robin)

Even when there is conflict, mostly over diagnosis, Robin experiences underlying respect from the physician in her effort to clear up the misunderstanding of diagnosis so that their working relationship would continue. For the two participants who provide the highest level of care for their more isolated communities, having support from physicians is paramount to their survival. They need to know there is someone at the other end of the telephone who respects their clinical judgment and supports their decision making.

Summary

Many factors are involved in establishing a new NP practice. Gaining knowledge about the community helps the NP create a place within the local health care system. Some of the participants involved in primary care pilot projects have a sense of accountability to the community as a whole for the development of their practice and how they will meet the health care needs of the community.

The support for new NPs to hone their advance practice skills for everyday practice comes from relationships built with physicians and other NPs. As the only NPs in their communities, the new NPs have developed a mentor relationship with local physicians and have made connections with other rural NPs for collegial

support. This support includes clinical trouble shooting, development of continuing education activities, and creation of policies and procedures.

Adequate resources support the participants in the development of their practices. In some provinces, legislation relating to prescriptive authority and referral process to medical specialists can delay the care provided by NPs. Many of the participants have also spent additional time to develop local policies and procedures to guide their practice. When local physicians control the parameters of the NP's practice through the approval of policies and protocols, growth of the NP's practice may be stunted if the physicians do not accept the nurse practitioner role as a collaborative health care provider. Implementation of policies and procedures that match the scope of practice needed for health care provision in rural and remote communities will also change the shape of the NPs' practice.

The relationships that nurse practitioners forge with the people they work with in their everyday practice, both at a distance and in their communities, are important for the development of their practices. Intertwined in the building of relationships are the personalities and communication skills of the nurses. As the team members develop an understanding of the role that the nurse practitioner can play in providing care for the community, the relationships with the NP take on a different shape.

Chapter Six: Discussion of Findings

The nurse practitioners in this study have shared their experiences of establishing a practice in communities that have not previously worked with nurses in an advanced practice primary care role. The analysis of the data has explored the interplay and impact of "being new" - being a new nurse practitioner in a new health care provider role for the community, province, and country and being a new member of the community. The interaction between the skills of the NP, the resources at hand and the dynamics of the people in the community make each NP's experience unique. And yet, all of the participants speak of similar challenges and opportunities. What connects the experiences overall are the time and support needed to establish, maintain, and build an ever-evolving practice.

As these nurse practitioners engage in the process of shaping their practice, they have found ways to gain an understanding of various aspects of the community that will influence the health care services they provide. They have found that taking the time to personally connect with the community, learning about the resources and people, to be mutually beneficial to integrating their role into the local health care services. In some settings, they have established the connection of health promotion with the practice of the NP and an understanding of the NP role. The care provided by the NPs is also dependent on the demographics of the people in the community and the expectations of health care services. Learning about the community has helped these nurse practitioners to know how to use their nursing skills in developing a practice that meets the needs of the community.

The resources needed by the participants in this study to build their NP practice are similar to other nurse practitioners in primary care settings. Appropriate office space, equipment, and practice policies are material resources needed in establishing a practice. Human resources include an understanding and acceptance of the NP role by office staff, physicians, administration, and the community. Unique to NP practice in rural and remote communities are the additional barriers caused by distance. Support from nurse practitioner colleagues occurs long-distance for all of the NPs in this study. Only a couple of participants have on-site managerial support. Support from colleagues and management outside of the community requires time to establish these relationships as well as an understanding of the practice issues encountered by the NPs. With management off-site and being the only NP in the community, the responsibility of setting and enforcing practice limitations is an additional challenge for most of the participants. Working in communities with limited health care services in primary health care roles, increases the potential for burnout of the sole nurse practitioner. Physician support and acceptance of the NP is especially important for NPs providing emergency care in their community as physicians are the first line of clinical support for these NPs working alone. As new healthcare providers for the community, the participants had to determine what skills they would need, the service they would provide, and how to integrate their practice into the existing health care services. To successfully integrate their new practice into the community and the local health care system, the NPs need time and support to grow and know.

Knowing Yourself and Being Known as a Nurse Practitioner

Highlighted by all of the participants was the importance of taking the time to know the community and build relationships. Recent literature stresses the importance of providing the time to develop NP roles that are new to the community and to the NP (Jones & Way, 2004; Schreiber et al., 2003). Whether it is clients, office staff, or physicians, getting to know the nurse practitioner as a care provider is fundamental to integrating the NP practice into the local health care system. The NPs in this study did this by meeting with the community members in whatever way that was suitable for the specific community: at town hall meetings, at community groups, or on an individual basis so that the people and the NP could begin to get to know each other. The experiences of these NPs show practical ways of getting to know a community.

What is unique about rural and remote practice is the interconnection between being a community member and someone who works in the community. The experiences shared by the NPs highlighted how their personal and professional lives are connected; and how their actions as NPs go beyond the walls of the workplace and influence their acceptance in the rural and remote communities as a professional and a community member. The literature identifies the high visibility of rural and remote nurses in their communities and the extra attention needed to maintain confidentiality outside of the workplace (MacLeod, Browne, & Leipert, 1998; MacLeod, 1998). Previous research with rural NPs supports the experiences of the NPs in this study regarding the time needed to build trust with a rural or remote community. The findings in this study reinforce the awareness that NPs working and

living in small communities must have to protect confidentiality of clients thus maintaining the respect of the individual and the community. It takes time to become a part of the community, and establish a trusting relationship which is the first step towards changing health behaviours (Baldwin et al., 2001; Tarlier, Johnson, & Whyte, 2003; Vukic & Keddy, 2002). While most of the NPs in this study are in the process of integrating their practice and personal lives into the community, the literature notes that NPs in rural and remote communities can experience a sense of isolation or being an outsider which is known to affect retention of health care providers (Kelly & Mathews, 2001; Nowgesic, 1995).

This study demonstrates how the NPs' daily work revolves around respecting the individual by maintaining confidentiality, working in partnership, helping to navigate the health care system, and integrating alternative health care practices to optimize health. An important piece of building an NP practice is the length of time for appointments with clients. The ability to book appointments that are 30-90 minutes for full physical assessments gives nurse practitioners the time to build a trusted and partnered relationship. Through the individualized care and education they provide clients, the participants demonstrate what it is that nurse practitioners do. Gould et al. (2007) echo the collaboration in practice with clients in their recent research. As well, previous research supports the findings in this study that clients are satisfied with the care provided and time spent with the nurse practitioner and that the NPs also value the time they can spend with clients (Brown & Olshansky, 1997; Gould et al., 2007; Horrocks, Anderson, & Salisbury, 2002; Knudtson, 2000; Reay, Patterson, Halma, & Steed, 2006; Wilson, Pearson, & Hassey, 2002).

Support from NP Colleagues

As the only NPs in their communities, the participants in this study have made the time to connect with NPs elsewhere and all speak about the unconditional support from other NP colleagues. They spoke about what it meant to have a colleague that knows what a NP is and should be able to do, to have support for clinical practice, education, and policy development. To know that they were not the only one going through their experiences, was and invaluable source of support for the participants. How and why the NPs connected varied with each of the practice situations. This study shows some of the ways that NPs in rural and remote communities seek out support from NP colleagues, even when distances are great and time is at a premium. When possible the NPs met in person to provide moral support to each other and create educational opportunities to continue their learning. Particularly relevant to the rural NPs in this study was the connection with colleagues by telephone and internet and the priority given to supporting other NPs during and after work hours. This study corroborates findings in the literature that face-to-face and telephone supports from colleagues decrease feelings of isolation and enhance job satisfaction (Andrews et al., 2005; Kelly & Mathews, 2001). Prior research has demonstrated that support from other nurse practitioners is vital to a new nurse practitioner; the lack of a peer support network is an ongoing barrier to the development of NP practices (Lindeke et al., 2001; Lindeke et al., 2005).

Working with Physicians

Key to the development of the NP's practice is finding a place and way to work with physicians. Because of the direct working relationship NPs have with

physicians, these health care professionals more than others, affect NP practice. The diversity of the participants' experiences in this study has shown how different practice settings and physicians' familiarity with advanced nursing practice roles influences the development of working relationships.

The types of practice setting, the presence of physicians in the community, and the nature of the collaboration in practice between NPs and physicians have a direct effect on the establishment of the NPs practice. The experiences of the NPs in this study show the range of working relationships with physicians and the challenges in establishing those relationships. Two of the participants, who provide the highest level of health care in their remote communities, have consultative relationships with physicians in other, more urban communities. A third NP's practice includes physicians on-site periodically, while the remaining three participants are working in interdisciplinary health centres. The experiences of the NPs in the health centres support the findings in the literature focusing on the evaluation of primary care centre pilot projects. The NPs in this study highlight the importance of having time devoted for team building and discussion of the distribution and expectations of health services provided by the NP (IBM Business Consulting Services, 2003; Jones & Way, 2004; OMA & RNAO, 2003).

The experiences of these rural NPs support previous research indicating the individual physician's level of knowledge about the NP role and their comfort level in working directly with NPs can be large obstacles in establishing a practice (Gould et al., 2007; Kulig et al., 2003; Schreiber et al., 2003; Tarrant, 2005). The experiences of the NPs in this study reaffirms that a good working relationship with physicians is

based on trust, respect, and acknowledges the complementary nature of the NP practice rather than viewing the NP practice as competitive with the care provided by the physician. The literature acknowledges working relationships with these qualities as supportive of NP practice in primary care settings. (Bailey et al., 2005; Jones & Way, 2004; Reay et al., 2006).

When a physician is also a mentor for a newly graduated NP, there is the opportunity for the physician to develop an understanding of the diversity of the NP role while supporting the NP in the development of her advanced skills. The new NPs in this study have experienced the increased support from physician team members as they develop their advanced practice skills as novice NPs, the need for which is emphasized in a recent report (IBM Business Consulting Services, 2003).

As the NPs build trusting relationships with the physicians and delineate care provision, they create a health provider role to meet everyone's needs. In primary health care centres, the challenges in developing NP practices are less when physicians are willing to work in interdisciplinary teams. For the participants working alone, providing urgent and emergency care, these relationships with physicians are vital to sustaining and supporting the NPs in their practice.

Support from Management

Parts of the challenge in establishing practices are the administrative and organization components that influence the development and acceptance of a new health care provider. The nurses' experiences in this study show how the lack of policy development and on-site management adversely affects the implementation of the NP role in the rural communities.

Health care administrators play an important role in the implementation and support of new NP roles. Very few of the participants spoke directly to having supportive management and only one NP had a manager in the community. Rarely mentioned in the existing body of literature are *managers at a distance*, an added concern for NPs in rural and remote practices. The literature notes that by planning prior to implementation of the NP role many of the barriers to implementing a new NP role successfully can be diminished or avoided completely. Planning includes providing clarity of the role, promoting full scope of practice, and creating a supportive environment (Bryant-Lukosius, DiCenso, Browne, & Pinelli, 2004). The experiences of most of the participants in this study, particularly those in pilot projects, highlight the lack of planning and support as they develop their practice. They are on their own as they develop protocols and negotiate care provision issues with physicians. This study is consistent with prior research that identified adding the NP role into an existing physician practice takes time and trust as well as the support from management in delineating the roles of the new health care team (Reay, Golden-Biddle, & Germann, 2003; Reay et al., 2006). This study also highlights that when physicians and NPs do not report to the same administration, challenges can arise for the NP in negotiating directly with the physicians on practice issues and development of policy.

Management also has a role to play in regards to the workload challenges of NPs working in underserved communities. Research has shown a connection between high workload demands and lower job satisfaction for nurses in rural and remote communities in Canada (Andrews et al., 2005), and a greater intent to leave

their current position when job satisfaction is low and the job requires the nurse to be on call for emergencies (Stewart, D'Arcy, Pitblado, Forbes et al., 2005b). The amount of overtime NPs work has also been correlated to lower job satisfaction (Bryant-Lukosius et al., 2007). The participants in this study raise the awareness of the high potential for burn out among NPs working alone in communities with few health care providers, and where guidelines and management support are not in place to prevent them from working into exhaustion. Those that are new to the NP role and/or working as the highest level of care provider for the community, are particularly vulnerable to stretching beyond their own personal resources, and structures need to be in place to support a healthy working environment. As the participants in this study have been in their current roles for less than five years, management practices to ensure the NPs feel valued and supported in their practice is an important retention strategy.

Summary

The experiences of the NPs in this study as they create new NP practices in rural and remote communities reflect many of the known obstacles and supports to incorporating nurse practitioners into the health care system. The most common obstacle is the lack of understanding of the role of the NP and how best to integrate their practice into the existing health care services. Support from management, colleagues, and the community and the time to develop their practice are important to the successful integration of the NPs' practice. The study adds to the understanding of the unique characteristics of rural and remote communities and the contexts within which NPs must develop their practice. The lack of on-site

administration for most of the participants adds to the challenge of establishing a new practice. In rural and remote communities taking the time to learn about the people, health and social issues, and resources available is vital to establishing a practice that will meet the needs of the community. Unlike their urban counterparts, NPs in rural and remote settings are an integral part of the community. They are always the NP even when they are not at work and need to be able to maintain the trust, respect, and confidentiality of the people of the community. Learning from the experiences of these NPs as they establish their new practice in rural and remote communities is important to understanding how to support other new NP practices.

Chapter Seven: Carving out a Place of Practice

The nurse practitioner as a health care provider in Canada has made great strides in the past two decades. The enactment of NP specific legislation and regulation in each province and territory has legitimized NPs as advanced nursing practice professionals. While the number of practicing NPs is growing, the role is still new and unknown. The newness of the role has meant that the participants have had to strive to carve out a place within the local health care system to provide care for clients.

The word carve implies shaping a hard material through painstaking effort and the experiences shared in this study demonstrate that shaping a rural or remote NP practice is challenging and not an easy process. Practicing at a distance from human and material resources is unique to the rural and remote practice settings, making the establishment of an NP practice particularly challenging.

An artist who works with materials such as wood or stone will tell you that the first step is getting to know the material, taking the time to see what it is like, and looking at it from different angles to see the possibilities. Each piece of wood or stone is distinctive; likewise rural and remote communities have their own characteristics. The participants have needed time to get to know the community to determine the potential shape of their practice. To be successful in carving out a practice that meets the needs of the communities, the NPs must be known as professionals and as community members. In rural and remote communities the two are intertwined therefore trust, respect, and confidentiality are key elements to a

health care practice that are earned once the NP engages with the community as a whole and with individuals.

Every carver needs a certain level of skill and the right tools. An artist carves a sculpture with an insight into the potential of the material and with the skills to reveal the shape within. As the participants have shaped their practices, the skills they have developed over the years enhance their NP practice and for those that are new NPs, provide a solid base to build their advanced practice. An artist will develop their skills through theory and practice, studying the work of masters or learning from a mentor. As the only nurse practitioner in their rural and remote communities, the opportunities for mentorship and ongoing education are limited. It is important to build working relationships with physicians as they are frequently mentors for new NPs. A collaborative working relationship with physicians is enhanced when physicians understand the complementary nature of the NP practice to their work with clients and are not threatened by this new health care provider.

Creating mutually supportive relationships with other NPs in rural and remote settings is an important resource for NPs as they build their practices. The support from other NPs who understand the context of a rural practice is invaluable in sustaining a new NP in the development of their advanced nursing practice. The collegial support from NPs in other rural communities is important for the development of skills, policies, and for the health and wellbeing of new NPs as they work in resource-limited communities to carve out their place as health care providers.

Unique to rural and remote nursing practice is how often management is not in the same community. Management can play an important liaison role in the integration of the NP's practice by supporting the NP in building relationships and integrating their practice with existing health care staff and providers. The experiences shared by the participants in this study highlight how in the absence of on-site management, the NPs are alone in their endeavors to integrate their practice and build relationships.

In carving out a place, rural and remote nurse practitioners face additional challenges not faced by their urban counterparts. The intertwining of personal and professional lives is a part of nursing practice in rural and remote communities. The limited human resources in the community, whether it be management, other NPs, or physicians put more onus on the individual NP, who often needs to seek support outside of the community. The struggles and opportunities shared by the participants in this study highlight the importance of developing working relationships that support the NP's practice as it is shaped.

Limitations of this study

The participants in this study are a cross section of the NPs in practice with varying levels of experience in nursing and advanced practice. While the number of participants was small, saturation in the main themes was achieved. The participants in this study are practicing in different provinces under different legislation and regulation. Some of the findings of this study may resonate with other NPs as they begin to carve out their place of practice in their own rural or remote community, yet

one must recognize the uniqueness of each community and how it may shape the practice of the NP.

The research question for this thesis was developed following the completion of data collection. The ability to explore in more depth the participants' experiences of establishing a new practice with probing and follow up questions in the interview may have provided more insights on the interplay between the skills, tools, and resources each participant had for the successful integration of their role into the community.

Implications

The findings from this study have implications for nurse practitioners, administration, policy, education, and research.

Nurse Practitioners

The experiences shared by the participants in this study highlight the importance of developing a presence in the community when beginning a practice. Because of limited human resources, NPs in rural communities have the opportunity to create unique multidisciplinary teams. As a new health care provider for the community, having the time to develop the role prior to beginning clinical practice is important to the integration of the NP into existing health care services. The NP needs the time and opportunity to explain the NP role to the community as a whole, and to individuals directly working with the NP. A community health needs assessment can focus health promotion and disease prevention aspects of the NP practice, while learning about the community and its resources can assist the NP with developing community specific ways of meeting those needs.

It is also important for NPs to have the time to develop mentorship and collegial relationships that will support them in the consolidation of their advanced practice nursing skills. Although the advanced practice role of NPs includes a high level of independence in the practice, the experiences of the NPs in this study have shown how much rural and remote NPs are on their own in their practice. They are the only NP in their community, they may or may not have physician colleagues in the community, and management is off-site. New NPs have to take the initiative to seek out support as they consolidate their skills, including working with a peer support network. Having ongoing support is vital to the growth of the NPs' practice and sustaining them in their practice.

If an NP has not previously worked in a rural or remote community, they must develop an understanding of the context of nursing practice in a setting where the personal and professional lives are not separate.

Administrators

In support of the development of the NP practice, administrators need to understand the unique characteristics of the rural and remote NP practice and the resources needed. These resources may be human resources in the provision of administrative and clerical support so that the NP's time is best spent with clients rather than doing non-nursing duties. Ensuring the development of local or regional policies derived from evidence based knowledge, prior to the implementation of the NP role will facilitate the initiation of clinical practice.

There are opportunities and challenges to providing health care in rural and remote communities. Support for NPs occurs when administrators are open-minded

to the ways in which NPs can provide services and be responsive to the needs of the people. Administrators can support the NP by providing time at the outset of a new practice for opportunities to meet with the community and other health care providers to learn about the culture, resources, and health care needs.

Policy

Policies that guide the practice of rural and remote NPs need to be appropriate for the context of practice and the resources available. If policies cannot be in place prior to the implementation of a new NP role, then dedicated time for the NP to create evidence based policies in conjunction with their collaborative practice team members and other rural NPs is crucial. The CNPI recommendations provide a framework for legislative, regulatory, and educational consistency at the national level which supports consistency for the roles and scopes of practice for NPs at the local level.

Education

The rural and remote NP participants in this study work with people across the lifespan with acute episodic illness, chronic illness, health promotion and disease prevention, and emergency care. The opportunity to mentor with an experienced NP in an established rural or remote practice would be beneficial to new NPs for consolidating their advanced practice skills. Developing connections with other rural and remote NPs early in their career provides the opportunity to establish a peer support network.

From the perspective of continuing education, opportunities that are appropriate for primary health care rural NPs need to be developed. Distance

education delivery is important as leaving their communities is not always feasible,

yet to contribute to the collegial support, regional interdisciplinary education

sessions, some of which would be interprofessional, would be beneficial.

Research

Further research exploring the experiences of a group of new nurse

practitioners within a specific province or territory could further the understanding of

how jurisdictional issues such as legislation and regionalization influence the shape

of rural or remote NP practices.

Results from the national study, of which this thesis is a small part, are

beginning to show the relationship between community and job satisfaction and the

intent to stay or leave a rural or remote community. Further exploration of this issue

with rural and remote nurse practitioners as well as the use of the *Barriers to*

Practice Checklist (Lindeke et al., 2005) in a survey would be beneficial to further

understanding the challenges and opportunities that are unique to this group of

health care providers.

<div align="center">Conclusion</div>

The experiences shared by the participants as they carve out a place for their

NP practice in rural and remote communities have shown that while there are

challenges and struggles, there are also many opportunities for providing health care

to rural and remote communities. As one participant said in her interview, "it's an

exciting time to be in this role because it's so new. We're kind of shaping the way.

So not only in rural nursing, it's the whole nurse practitioner thing that's very new."

The recognition of the NP role on a national level will only strengthen the work done by these pioneer NPs in rural and remote communities.

The community, the NP, and the resources available influence the shape of the NP's practice. By learning about the experiences of these rural and remote NPs in establishing their practice, the identified barriers can be reduced and the supports enhanced to promote job satisfaction and ultimately retention of these much needed health care providers.

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Appendix A

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

UNBC

3333 University Way, Prince George, BC V2N 4Z9

Dr. Alex Michalos
Chair, UNBC Ethics Review Committee
Tel: (250) 960-6697 or 960-5820
Fax: (250) 960-5746
E-mail: michalos@unbc.ca

UNBC Ethics Committee

August 24, 2000

Martha MacLeod
c/o Nursing

Proposal: EP20000704.51

Dear Prof. MacLeod:

Thank you for responding to the comments about your proposal entitled, "The Nature of Nursing Practice in Rural and Remote Canada."

Your proposal has been approved and you may proceed with your research.

If you have any questions, please feel free to contact me.

Sincerely,

Alex Michalos
Chair, UNBC Ethics Review Committee

Appendix B

The Nature of Nursing in Rural and Remote Canada
Participant Information and Consent Form

Research Project
The Nature of Nursing Practice in Rural and Remote Canada

Co- Principal Investigators
Dr. Martha MacLeod, University of Northern British Columbia (UNBC) (leader of
    Narrative study)
Dr. Judith Kulig, University of Lethbridge
Dr. Norma Stewart, University of Saskatchewan
Dr. Roger Pitblado, Laurentian University

Purpose of Narrative Study
We are inviting your participation in this study to learn from you what it is like to be a
nurse in health care settings within rural and remote Canada. This narrative study is
part of a larger study that includes a Canada-wide survey, analysis of the Registered
Nurses Database and examination of documents on nursing.

Benefits of the Study
This study will foster a better understanding of:
1. the roles and functions of registered nurses in rural and remote Canada;
2. what is similar and different in these roles and functions across broad
   geographical areas;
3. what features of practice contexts contribute to the development of
   nursing expertise;
4. what organizational and policy supports will benefit rural and remote
   nurses.

This research will help policy makers and managers in making decisions about
practice, recruitment, retention and education of registered nurses in rural and
remote Canada.

What would be expected of you?
You are invited to participate in an interview in which you will be asked to tell about
your experiences working as a nurse in rural and remote settings. If you decide to
take part in this study, upon the return of your written consent (see page 3), you will
be contacted by one of our research team members, and an interview will be set up.
The interview would be audiotaped and then transcribed. You are welcome to
participate in a way that is comfortable for you. The options for participation include:
individual telephone or face to face interviews (where possible), or if you prefer you
can respond to the questions in writing. Estimated length of the interviews is about
one hour to an hour and a half, but flexibility with regard to time will be built in.

Confidentiality
The interviews will be kept strictly confidential and will be available only to the researchers. Your name will not be used. A coding system will be used to protect your anonymity. The information from the interviews will be grouped and an advisory team, consisting of expert rural and remote nurses and decision-makers, will assist with the analysis and interpretations. Practising nurses in various rural and remote settings will be asked to review selected themes how closely the findings match their own practice. If you are interested in being involved in this process, please indicate on the consent form. Excerpts from interviews may be made part of the final research report and other documents, and every effort will be made to protect your confidentiality and anonymity throughout the research process.

Your Participation
We would like to assure you that as a participant in this project you have several rights. Your participation in this research is entirely voluntary. You are free to withdraw from the interview process at anytime. You can refuse to answer any of the questions.

Contact Persons
If you have any concerns or questions before commencing, during or after the completion of the project do not hesitate to call:

Martha MacLeod RN PhD
University of Northern British Columbia
Associate Professor, Nursing Program
Phone: (250) 960 6507   1-866-960-6409
email: macleod@unbc.ca

Max Blouw
University of Northern British Columbia
Vice President, Research
Phone: (250) 960-5820
Email: blouw@unbc.ca

Thank You.

THE NATURE OF NURSING IN RURAL AND REMOTE CANADA
Consent Form

I Hereby consent to be a participant in a research study to be undertaken by Martha MacLeod RN, PhD of the University of Northern British Columbia and a Canada-wide research team. **I understand** that the purpose of the research is to explore the nature of nursing practice in rural and remote Canada.

I acknowledge that

1. My participation in the research may be in the form of an individual interview, which will be audiotaped and transcribed, or a written narrative.

2. The aims, methods and anticipated benefits of the study have been explained to me.

3. My name, name of my community and any other identifying information will not be used throughout the course of this study in order to protect my confidentiality and anonymity.

4. I voluntarily and freely give my consent to my participation in this research study.

5. I understand that aggregated results will be used at the provincial, regional and national levels for workforce, educational and recruitment planning. The research will be reported in written reports, academic journals and other communications media.

6. Individual results will not be released to any person except at my request and on my authorization.

7. I am free to withdraw my consent at any time during the study, in such an event, my participation in the research study will immediately cease and any information obtained from me will not be used.

8. Recorded data from the research will be kept under lock and key for an indefinite period of time. The data may be used in other studies.

Name: _____

Address:_____

Phone: _____ **Email:** _____

Signature: _____ **Date:** _____

I would like to participate in reviewing selected themes during the analysis of data stage: (Please circle)   YES   NO

If you have any questions or concerns please do not hesitate to contact Martha MacLeod at (250) 960 6507 or 1-866-960-6409 Fax: 250-960-5744   http://ruralnursing.unbc.ca
email: rrn@unbc.ca
Mail to: Nature of Nursing Practice Study,
          Nursing Program, University of Northern British Columbia,
          3333 University Way, Prince George, BC V2N 4Z9
Thank you for your contribution to this research.   **(Copy to participant)**

Appendix C

The Nature of Nursing Practice in Rural and Remote Canada
Narrative Component: Interview Questions and Probes

Begin by introducing yourself - as a registered nurse..... NOTE: It is not as important to get through all of the questions. Try to get a few situations.

1. What is it like to be a (type of role) _____ nurse, in (setting) _____ in (town/village) _____?

2. What kind of agency/organization do you work in?

3. Can you tell me about the community(ies) in which you work? (size, economic base, geographic location, cultural makeup)

NOTE: These first 3 questions could be covered by: Tell me how you came to be a ____ nurse in ____.

4. Could you describe a typical day/week like for you

5.*Could you tell me about:

A situation in which you feel your nursing care really made a difference in patient/client outcome, either directly or indirectly

A situation that went unusually well

A situation that is very ordinary and typical

A situation in which there was a breakdown (i.e. things did not go as planned)

A situation that you think captures the quintessence of what nursing is all about

A situation that was particularly demanding

Probes:
Could you tell me more about what was going on at the time?
Why is the situation significant?
What were your concerns at the time?
What were you thinking about as it was taking place?
What were you feeling during and after the situation?
What, if anything, you found most demanding about the situation?
What helped you to deal with the situation?

6. Can you think of patients/clients in the last few weeks, who have been memorable?

     - Compare to earlier in your career

7. What is most challenging to you now in your practice?

     - Compare to earlier in your career

8. What sustains you in your practice?

9. Can you tell me about a situation that will illustrate what it means to be a nurse and a member of the community?

10. What does learning through experience mean to you?

11. What advice would you have for:

     - New nurses coming into your situation?

     - Planners of educational, practice and administrative supports?

12. Do you have any final message you would like to give the researchers?

Demographics:
Position: former, chronology
Education:
Professional Qualifications:
Doctors/other colleagues: Organization/Length of time working with
Physical set-up: office location/clinic/unit layout, equipment, environment – effects on nursing care.

NOTE: You do not need to ask for all of the situations, but ask for at least 2 or 3 of them. The goal is to get the nurses to talk about their experiences fully in with as many particulars as possible. Please make sure you ask all people question 10.

Note: Question 4 is from Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice.* Menlo Park, CA: Addison Wesley.

Other questions from MacLeod, M. (1996). *Practising nursing: Becoming experienced.* Edinburgh: Churchill Livingstone, and MacLeod, M. (1998). *"We're it": The nature of nursing practice in very small rural and remote hospitals in Northern British Columbia Canada.* University of Northern British Columbia: Author.